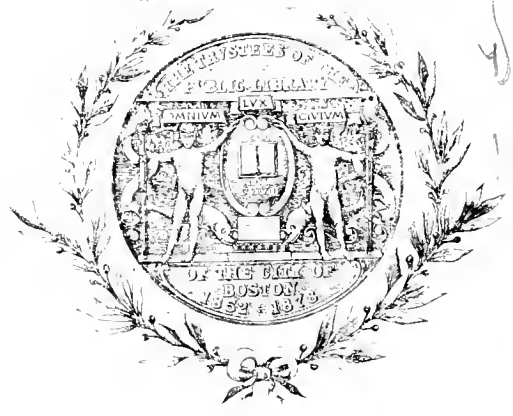

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JANUARY • FEBRUARY 1957

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Adjustment to School Entry

Preventing Mental Illness

Research Needs in Delinquency

Training to Teach Corrections

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Story time in a nursery school. At the very beginning of years of school attendance, these attentive children may or may not continue to find school an absorbing experience, depending not only on what the school has to offer them, but also on what they bring to it. How much expectations of school and burgeoning independence from mother have to do with school adjustment is considered on pages 3–8; while several pitfalls in the school's role are pointed out in excerpts from a UNESCO report quoted on pages 30–31. One way of helping teachers recognize and handle children with incipient problems is described in the article on page 9.

◀ *the authors*

Dr. Kenneth Soddy divides his time between clinical work and teaching in child psychiatry in London, in addition to his work for the World Federation for Mental Health. He was editor of "Mental Health and Infant Development," the two-volume report of the Federation's seminar at Chichester in 1952, which he directed; and co-author, with Dr. R. F. Tredgold, of the ninth edition of "Tredgold's Textbook of Mental Deficiency."

Prior to World War II, when he was a flight surgeon in the Air Force, Dr. Norman Nixon practiced pediatrics in Los Angeles. After the war he obtained psychoanalytic training at Columbia University and experience in child psychiatry at the Jewish Board of Guardians and the Babies Hospital, New York. Since 1949 he has been in his present job in Philadelphia where he also serves on the faculty of the Departments of Pediatrics and of Psychiatry of the University of Pennsylvania Medical School and the Graduate School of Medicine.

This is the third time CHILDREN has been a vehicle for some of Fritz Redl's many ideas. Nearly 3 years ago he participated in the debut of the journal with his explanation of his study of disturbed children at the National Institute of Mental Health, then just beginning. A year later he wrote his observations of the many things he had learned about defiance in young people. Among his many other publications is the book "Children Who Hate," written in collaboration with David Wineman.

Before going to Korea two years ago Helen R. Tieszen was a nursery school teacher at the University of Minnesota where she obtained her master's degree through the Institute of Child Welfare. Previously she spent two years at the State University of Iowa teaching preschool children in hospitals. She is a native of South Dakota. Rose Alvernaz, her colleague in the training program she describes, was previously consulting social worker to Brazil on loan from the Children's Bureau, U. S. Department of Health, Education, and Welfare.

Elliot Studt has been looking for ways of improving work with delinquents since the early forties when she and her husband were respectively assistant superintendent and superintendent of the Denver Detention Home. Before coming to the Children's Bureau's Division of Juvenile Delinquency a year ago, she was head of the correctional specialty at the School of Social Welfare, University of California at Berkeley. A graduate of the University of Denver's School of Social Work, she has been working for her doctorate at the New York School of Social Work.

A British child psychiatrist considers some of the factors involved in a child's . . .

ADJUSTMENT TO SCHOOL ENTRY

KENNETH SODDY, M. D.

Assistant Director, World Federation for Mental Health, London, England

A SUBJECT like school entry is likely to have as many different aspects to consider as there are varying communities and cultures. In discussing them I shall confine myself to my own culture, while attempting to present my case in the form of general principles that have a reasonably wide validity. Perhaps the most important aspect concerns the expectations of the children themselves regarding school. In this respect, in Great Britain, for more than 80 years, every child has expected to go to school at the age of 5. This fact establishes a very significant set of conditions.

School is a product of civilization, unnecessary in primitive society. Even in a highly civilized community that is traditional and agrarian, probably only 2 or 3 percent of the people need to be literate, for nothing will happen to them that cannot be dealt with by invocation of precedent or by memory. Margaret Mead has defined the concept of the wholeness of human beings who are protected always by well-known and closely related people.[1] Such people have no need of extra-familial learnings to enable them to cope adequately with life.

Dr. Mead has also referred to the price paid by people for the style of life they lead. This price in an ultra-stable, unchanging, underdeveloped community, such as can still be found today in Samoa, is paid by people with unusual gifts for whom the community has no place. On the other hand, as civilization begins to increase the complexity of life, the family cannot supply everything that the child needs to equip him, and one price to be paid by the developing community may be the necessity for some or all of its children to adjust to school. At least, as towns develop, the need for literacy will increase; and so schools will be started, at least for the few.

Illiteracy cannot be tolerated in a modern, urbanized, industrialized community. Great Britain was among the first, if not the first, country to experience industrialization and is now one of the most intensively industrialized. For nearly 200 years an enormous volume of internal migration has taken place there, and during the last 100 years the pace of social change has been ever increasing. We have reaped one very great advantage from our role as a pioneer—that the change has not been forced upon us by purely external circumstances, so that it has proceeded at a pace no faster than that to which the community has been able to adapt itself. We have evolved new forms of social living, new social habits that have enabled us to maintain an unbroken cultural development, in spite of profound change. We have also suffered greatly from our position as pioneer in having no guidance from other peoples' experience, so that we have despoiled an undue proportion of our resources.

Growing recognition of the necessity for a literate population culminated in Britain, in the 1870's, in the momentous social innovation of compulsory, universal, primary education in schools. We are now in our fourth generation of compulsory school attendance, and none of us can remember an era in which all children did not go to school. Nobody, least of all the child himself, questions the assump-

Based on a paper presented at the Ninth Annual Meeting of the World Federation for Mental Health, Berlin, Germany, August 1956.

tion that a child will go to school at the age of 5. On the whole our children are well adjusted to the prospect. Of course, 5 years is an earlier school entrance age than most countries have, but I believe that the actual age of entry is a less important influence than the expectations of all concerned.

We have, in fact, gone one stage further than mere unquestioning acceptance of school. For many years, if an individual child happened not to be ready for school at the usual time, it was assumed that there must be something wrong with the child, the parents, or both. Nowadays, the whole subject is becoming more self-conscious: we are aware that school is an artificial and not a natural affair; some of us recognize the illogicality of dooming a child to be abnormal for not being ready at an arbitrarily determined age to do something quite artificial. We are beginning to recognize a possible need to prepare child and family for school entry and to study factors that make for adjustment, or which disturb children in the easy acceptance of duties that society thrusts upon them.

Intent on her drawing board a nursery school pupil lets the joy of creation take her mind off her separation from mother.

Child Factors

Let us now examine briefly some of these adjustment factors from the angle of child development. It is very remarkable how the two main factors—learning and maturation—are inextricably mixed up from the very first. For example: the sucking of the newborn infant results from an innate reflex, but it is inefficient. Within 1 week of a child's birth his sucking will have developed into an efficient feeding process. Typically, learning in early childhood takes place speedily on top of an innate pattern of maturation. Resulting skills will then contribute to the child's capacity to acquire yet new experience, and in this manner education will proceed, by a kind of spiral.

One might generalize that all learning is positively oriented, either directly or indirectly, toward the fulfillment of instinctual drives, to overcome their frustration, or in pursuit of the sublimation of an instinct. When mental conflict is present, learning may be oriented away from the instinctual direction, that is, negatively to the instinct.

Successively in time, man is a solitary, then a social, then a reproducing animal. Clearly, no child will be ready for school until he has become a social animal. How does he achieve this? First, the necessity for the establishment of independent life and for growth makes feeding the primary concern of the infant, and the alimentary route of learning infinitely the most important. A very few weeks later, the baby's manifold activities involving movement and space become important as a route of learning about himself and the environment. From his infantile position of egocentricity, helplessness, privilege and feelings of power the baby grows up, first by the formation of a relationship with his mother, then by progressive modification and control of his instinctual drives, by orientation in space and in family life, differentiation of sex, formation of social relations, and so on. In all of these processes, maturation and learning are inextricably mixed up.

Modern studies in animal ethology have rediscovered the fact, neglected in the first flush of enthusiasm for the dynamic psychology of the individual, that man is a herd animal. Once again scientists are beginning to recognize the existence of certain primary instinctual drives toward the formation of social relationships and the inhibition of egocentric and antisocial trends. Normally the child's mother will meet these drives more than half way and between the two a firm, if simple, relationship develops.

So important are social trends in the baby that when he is only a few months old, at the first major clash between ego-centered and social instinct, victory goes to the latter. The cardinal example is in weaning, when the child, by virtue of the social relationship that has grown up with the mother, abandons

the easy and well-practiced process of feeding by sucking and acquires the new and initially difficult skill of feeding by biting and chewing. Success in this transfer is rewarded by a more varied diet, joy of achievement, a greatly enhanced relationship with the mother, an increased sense of self, and, most important, a favorable attitude toward any future new experiences introduced to him by his mother.

This is one of the great paradoxes of child development: the triumph of social over ego-centered instinct results in the firm establishment of self. If the ego-centered instinct were to prevail, the child's babyishness would be confirmed, his sense of self in relationship to the environment would be weakened, and he would be likely to show resistance to or rejection of change thereafter.

In succession the great learning experiences of the toddler go on, and each new attainment and skill is gained with mother's help and, in a sense, for mother's sake. Social drives are strengthened, ego-centered drives are weakened and the self becomes more and more established in true perspective in the environment. With the help of the mother the original instinctual drives of the baby become modified and directed toward objects further into the future and more acceptable socially. The child's success in this will strengthen the self to such a degree that he will become capable of undertaking for himself the control of his own instinctual drives. This vitally important development will free him for new acquisitions and new learning experiences by himself and without the help of his mother.

A parallel development of profound importance is that the child's relationship with his mother will itself undergo changes and developments that permit him to form relationships with other adults. He will give up both his absolute dependence and his absolute demands upon his mother and will transfer something of his relationship with her to his father, to other adult relatives and, rather later, to other adults too. This opens up the possibility of the child's being capable of learning from a school teacher. Concurrently, his relationship system will begin to include his brothers and sisters, in mutual affection as well as rivalry, and, later, other children as well. The child will be ready to enter school, to the extent that he has been able to give up his infantile need to be the center of love, is able to take his place as a member of a group of equals, and is able to transfer part of his relationship with his mother to other adults.

There is, therefore, a threshold of development below which it is not reasonable to require a child to adapt to school. If I may recapitulate, the threefold aspects of development required are: 1) ability to tolerate not being the sole center of love in the family; 2) a sufficient degree of emancipation from the exclusive tie of mother love to be able to transfer part of his dependent relationship on to other adults; 3) ability to enter contemporary child society on a basis of equality, of give as well as take.

Danger Signals

If the child has failed to adjust anywhere along this line of development he may be in a situation in which he will be compelled by environmental pressure to undertake a new development for which he will be ill-equipped. Children so placed show, almost universally, the phenomenon of regression, or the reversion to an earlier and younger pattern of behavior.

Reverting to younger ways is normal enough as a transient phenomenon, passing off within a few minutes or as soon as the child's attention is diverted to something else. Most children show a diurnal variation in this respect—they will spend the last half-hour of the day at a younger level of behavior than the rest of the day. Regression, however, can be more permanent and can be an apparently irreversible return to a younger type of behavior. When this has happened the child will show up as being babyish. In our culture at least, we find it very difficult to tolerate a babyish child. A regressed 5- or 6-year-old will stand the risk of being repudiated by parents and siblings, teachers, and other children. In this sphere, nothing fails like failure; everyone is hard on the regressed child and this will serve to fortify his regression and greatly increase his difficulties.

In addition to the almost ubiquitous regression, there are three types of reaction that are danger signals that a child is not adjusting well to school:

1. Withdrawal. Commonly among introverted or in-turning children difficulty will be indicated by a daydreaming, wool-gathering slowness that has all the worse after-effects because the child's developing intellectual powers at this age will enable him to get his emotional satisfactions in fantasy rather than in the real world.

2. Overactivity. Extraverted or out-turning children may become overtly anxious, over-active and over-excitable. Such a child will be highly distractible, restless, and grasshopper-minded and his

teacher may report of him that "he cannot concentrate." This report, one feels, is neither more nor less than the simple truth.

3. Inhibitions. Most serious of the danger signals, this can occur both among in-turning and out-turning children. Among the former the reaction of inhibition will be painfully apparent: the inhibited, in-turning child will be rigid, shy, withdrawing, incapable of spontaneity of response or of friendship, and most obviously miserable.

On the other hand, an inhibited, out-turning child may exhibit puzzling paradoxes in behavior. At first glance he may appear to be easy, friendly and unremarkable: he will not attract the hostility of other children as does his more in-turning opposite number; but his very easiness and openness may mask a painful degree of inhibition of effort. Without inhibition he would, perhaps, be boisterous and cyclothymic: but with inhibition, because of the extraversion of his temperament he merely shows up as being passively open-natured. He will usually be quiet, well-behaved and even over-controlled, but he will also probably have a striking tendency to fly into panic rage states when circumstances get beyond his powers of control. Thus there will be a paradox that though he will be passively friendly in society he will, in fact, be a poor mixer; though he is unable to stand up for himself and unable to express his emotions he may, at times, display a quite frightening degree of violence.

Absorbed in a project these children seemed to be having no trouble adjusting to school at the time they were photographed. In addition to school program, many factors in a child's preschool life can influence the degree of his school adjustment.

In class the inhibited extrovert will do little or nothing, and this will puzzle his teachers because he will not appear to be inattentive and daydreaming like the in-turning child, nor restless, distractible and naughty like the out-turning child. Commonly teachers fall back on that age-old formula: "He is lazy," or "bone idle." Yet, in my experience, it is rare to find a really lazy child. No doubt many children will shirk uncongenial tasks, but something can always be found into which a child can pour his energies without stint. This is not so in the case of inhibited children. They seem to be incapable of any form of direct expression of aggression and in school are no more capable of "attacking" their lessons than of fighting the other children. One such child had as a report from his teacher: "Could do better if he tried," but as my colleague, Dr. Mildred Creak, remarked: "The truth of the situation would have been better expressed by reporting, 'could try if he were better'." [2]

Family Factors

Let us now turn to consider some of the family and social aspects of school adjustment. We have noted that school is a product of a highly differentiated type of urban civilization. It is unnecessary in an agrarian culture in which all the educational experiences that are required can be provided within the extended kinship system. But the product of such a system will be an extreme narrowness of interest and a lack of adaptability to change.

In our modern towns the families have broken up into simple units, and intercourse between the various generations has become less intimate. Family life has long since ceased to encompass within it all that a child need know. As far as cognitive learning is concerned, studies in child development have shown that at about the age of 5 or 6 a great advance occurs in the child's capacity to deal with cognitive experiences in an organized way. These facts justify the academic side of school life.

However, education of children also includes experience of social living. School has an important role to play in unifying the diverse elements of the child's experience. One important feature of modern urban, industrial life is the sharp separation of the place of work from the home. This may lead the child to reflect in his attitude toward going to school his parents' attitude that going to work is something to be endured in order that emotional satisfactions may be gained at home and in one's spare time. Thus going to school may be divorced, in the child's

mind, from the real business of life which, he may feel, is the gaining of emotional satisfaction in the home—a divorce with most unfortunate consequences to the child's future attitudes. This tendency may be most extreme in a child whose mother has gone out to work since his earliest recollection. Such a child may conceive of work, and thus later, of school, as something in the nature of a deprivation, an infringement of just rights, an intolerable encroachment upon instinctual necessities.

The future inevitably will present constantly and rapidly changing social conditions. Anthropologists suggest that the best way in which to create a culture that can adapt successfully to change is to ensure that children adapt *early* to the exigencies of life in a group of their own age. In a well-run school a child can become accustomed to a rapid change of social climate while still enjoying the security of group membership and, ultimately, of control by well-disposed adults.

Many features of modern town life make it difficult for a child to acquire the necessary social experience for easy adaptation to school. As Dr. Creak has pointed out, many parents deny their children the opportunity to play in the streets, where they might learn the rudiments of social living in a group of contemporaries, because our streets are neither safe nor desirable as playgrounds. For the child to be left by himself on the balcony of an upper story flat, is for him to be left alone. This aloneness makes for clinging and demanding behavior; or else withdrawal into the self; or aimless and destructive play that may have explosive results in a flat full of hire-purchase furniture. In families with one or two children, the child's world, as such, does not exist; the child must compete for a place in the adults' world, with resulting behavior that parents may not understand and needs that they may fail to satisfy. This adult world will stimulate the child at an age when he still has incomplete control of his feelings and when he very likely has inadequate space in which to try out his new found discoveries.

Parental Difficulties

Space limitations do not permit me to go exhaustively into the various forms of parental difficulty that may make for trouble in the family at the time of school entry. The most common is presented by the parent, more often the mother, who brings up her child as an extension, as it were, of her own personality. Throughout the character-forming period of her child's early years, such a mother will have trouble helping the child to acquire a measure of independence from her, to modify for himself his own instinctual drives and to control for himself his own primitive wishes. This kind of parental difficulty may result in the child's exhibiting one of the three danger signals already mentioned.

Another form of difficulty is presented by the mother who is able to deal well enough with her infant or toddling child to give him a sound basic relationship and security, but who, when the time comes to introduce him to wider relationships, cannot bear to let him go; or who, having by this time a younger child as well, maintains a toddler regime for both children. Though this mother may experience no marked or obvious difficulty in bringing up her children, other than a certain tendency toward babyishness in them; she may, in fact, sabotage their independence to such a degree that when they reach school age they will interpret in their behavior her real, if also unconscious, need for them to show themselves still to be dependent babies, still unable to tolerate the separation from her that going to school entails.

The most common sign of prolonged mother-child interdependence in my country, I believe, can be found in the child who goes to school with little or no demur but who will not take his dinner there. By refusing dinner the child interprets faithfully his mother's deep jealousy of anyone else's attempting to provide for her child. Acute refusal to go to school a few weeks after starting, and intense misery prolonged over a period of months, at least for the first few minutes of each morning and afternoon, are also symptoms commonly due to this or a similar cause. Almost every influence that such a mother brings to bear upon her frightened or protesting child tends to increase his dependence and decrease his ability to succeed.

However, we ought not to forget that the child who is forced by a neurotic or immature mother to act out her emotional conflicts for her, may not be in any very desperate straits if his basic relationships and processes of instinct modification are satisfactory. For, at the school there will be adults whom he can love without feeling a compulsion to attempt to possess completely; and whom he can hate too, at times, without feeling unbearably guilty about doing so. The other children will not be in fierce competition with him for the exclusive possession of the adults. In contrast to the emotional atmosphere of his own home, the atmosphere at school may be relaxed, easy and conducive to confidence. The child's-

exploration of the concrete material of learning will become the basis of later exploration of the world of ideas; his entry into the group life of school will be no longer playing at life, but will be living in play—the basis for his later full entry into the social life of human society.

In Conclusion

As in the case of so many other problems in the field of mental health, difficulties in school adjustment commonly have their origin in early childhood. Consequently the capacity of the social institution concerned—in this instance the school—to deal with the difficulties of children in adjusting to it is strictly limited. Of course, a great deal of planning is required to make school entry as easy and appropriate and congenial to the children as possible. The premises should be attractive and well designed; the school regime and style as well suited as possible to the physical and mental needs of the children. Above all, teachers should have sound motivation and reasonable emotional maturity themselves.

School can prove of great use in helping the child with sound basic relationships but inadequate social experience after early infancy to adjust and find delights in community life. But school of itself is not well placed to deal with the deeper maladjustments and developmental failures of early infancy. These need to be tackled by agencies allied to, but other than, the school itself. If the child is below the threshold of personal emotional and social development needed for adjusting to school, it will do little good to expect the school to act as what Dr. Creak has called "a weaning factory to deal with the clinging child."[3]

The child who is not yet weaned psychologically cannot be helped to get over his difficulties by the school acting alone. Without others taking measures, too, he will probably continue to show difficulties for years, if not for the whole of his life. Such a child needs helping on a broad basis of mental hygiene work, that takes into its wide sweep of consideration such matters as the mental health of the parents, their emotional maturity and the style of life which is being lived by the family.

In other words, the problem of school adjustment is not an isolated subject, but is one of many aspects of the complex social life in our modern urban, industrialized communities. I need to make no apology for having arrived at the conclusion that problems of school entry, like most other problems of children in the field of mental health, can only be fully and satisfactorily dealt with by a wide program of preventive mental hygiene embracing family life, social organizations, the teachers, and the parents, as well as the child himself or herself, for this is the way of the mental health world.

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[1] Mead, Margaret: The concept of mental health and its international implications. Paper presented at the ninth annual meeting of the World Federation for Mental Health, 1956.

[2] Oral communication to the Ministry of Education Committee on the Treatment of the Maladjusted Child in the Education Service.

[3] Proceedings of the Annual Conference of the Royal Society for the Promotion of Health, 1956. Mental Health Section.

THE CHILD is the person who will continue what you have begun, who will sit right where you are sitting and witness the things you consider very important when you have gone. You may take all the measures you like but the manner in which they are carried out will depend upon him. Even though you may sign alliances and treaties it is he who will execute them. He will take his seat in the Assembly and will assume control of cities, nations and empires. It is he who will be in charge of your churchs, schools, universities, councils, corporations and institutions. All your work will be judged, praised, or condemned by him. The future and the destiny of humanity will be in his hands; therefore it would not be a bad idea to pay some attention to him NOW.

Translation of a Christmas card sent out by the official children's agency in Panama, 1944.

Adapting a variety of techniques to avert mental illness . . .

A CHILD GUIDANCE CLINIC EXPLORES WAYS TO PREVENTION

NORMAN NIXON, M. D.
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THE CENTURY-OLD INSTITUTE of the Pennsylvania Hospital in Philadelphia has been the site of many "firsts" in psychiatry, in treatment, in training, and in research. However, until the Child Study Center was established there in 1948, its focus had been almost exclusively on the treatment of emotional and mental illness in adults. With the development of the Center's program, the emphasis has shifted to the preventive aspects of psychiatry—the averting of serious breakdown through the early detection and treatment of children and families showing symptoms of emotional maladjustment. This goal involves the Center in a four-pronged function.

1. To provide psychotherapy for children and their parents;
2. To train psychiatrists, social workers, clinical psychologists and nursery school teachers;
3. To carry out research on mental health principles and professional practices (a full time research director heads this phase of the program);
4. To provide mental-health education for professional and lay persons in the community who are working with children.

Housed independently in four wings of the Institute, the Child Study Center receives its financial support from foundations, State and Federal grants, the Community Chest, dues collected by its membership association, and modest fees paid by families who receive psychotherapeutic services at the clinic. These patients are chiefly from the lower income groups. The staff includes 28 full-time professional workers—child psychiatrists, psychiatric social workers, clinical psychologists, and nursery teachers—12 clerical workers and a large number of volunteers. An Advisory Board of laymen supports the Center's focus on prevention.

The Center consists of three units:

1. The *Children's and Adolescents' Unit* which provides out-patient psychiatric service to children 6 through 18 years of age, and their parents. *Both* father and mother are seen if the family is intact.
2. The *Preschool Unit* for the diagnosis and treatment of emotionally disturbed children under 6 years of age, and their parents. A special nursery provides selected children with a group educational experience which supplements the treatment program.
3. The *Nursery School* for 34 carefully screened "normal" children to supplement the Center's training and research programs. In planning the training program we have asked ourselves: "How can child psychiatrists and other professional work-

ers really understand what is pathologic unless they can observe a number of normal pre-adolescent children in action, day by day, as they progress through the different phases of personality development?"

These units provide the laboratory experience for underpinning the Center's educational efforts for persons who work with children. These efforts have been channeled chiefly through two unusual devices: open house case presentations and special child-health conferences.

Open House Presentations

Open house case presentations are held at monthly intervals from October to May. Announcements are sent to a list of 1,400 community leaders who, collectively, work with a large percentage of Philadelphia's children and teen-agers. They go to school counselors, principals, attendance officers, teachers, probation officers, police, physicians, nurses, scout leaders, clergymen and others.

The Institute's auditorium is usually filled to capacity, with many standees, while the staff team of child psychiatrist, social worker and psychologist presents a 45-minute summary of a case—including the diagnostic evaluation of the child's problems and the total family situation—and highlights of the clinic's contacts with the child and both parents in therapy. For the next 35 minutes the audience is invited to comment, to ask questions, to agree or to disagree, with the director serving as moderator. Almost always a lively discussion ensues. During the final 10 minutes of the 1½ hour meeting, the director summarizes the case and comments briefly on some of its aspects—phobias, delinquency, bed-wetting, learning difficulties, feeding problems, childhood psychosis or whatever they may be.

The history of these open house case presentations covers the last 6 years, during which the staff learned, through trial and error, effective ways of presenting basic psychiatric concepts to a group of community leaders. At first the audiences included hardly more than 20 or 30 people, but the auditorium began to fill up as the staff learned to talk simply—but never "down" to the audience—using understandable, every-day language and avoiding psychiatric terminology. A former U. S. Senator, intelligent and erudite, gave us the clue in one of the first meetings when he asked "Just what is a sibling, anyway?" In the same audience a school principal wanted to know the meaning of "castration anxiety."

Some of the most heated audience reactions, both during the meetings and in subsequent individual communications, followed staff discussions in which psychoanalytic interpretations, particularly regarding psychosexual conflicts, were couched in analytic terminology. Gradually, the staff learned to say the same things in simple words and phrases that held meaning for most of the audience. Of course, through the years, the audiences have learned and matured too, so that now the staff can say many things which formerly would have been misunderstood or not understood at all.

Psychiatrists, social workers, and psychologists need to be given a training opportunity to learn "to think on their feet" so that they can communicate their ideas clearly and briefly to both lay and professional audiences. The "open house" provides a wonderful training ground in this respect for our staff. When a social worker is allotted 9 or 10 minutes to give a clear picture of the home and the parents' background, and when she is asked to cover 20 or 30 treatment sessions in 6 or 7 minutes, well enough for the audience to sense what went on in therapy and what psychotherapy entailed, she needs to do a great deal of preparation. Similarly, the psychiatrist, who often is too verbose when he talks or writes for the public, is hard-pressed when he must present the child's developmental history, the problem, his diagnostic impressions and his treatment contacts all in the 19 minutes or so allotted to him. The psychologist too finds it difficult to translate in simple terms, in 5 minutes the results of his testing of the child so that the audience, as well as other members of the staff who are hearing the presentation for the first time, can benefit from his contribution.

Careful Planning

Each 45-minute presentation is carefully planned, timed to the minute like a radio or television program. One run-through several days in advance helps the team members to sharpen their material and get the presentation into final form. Coaching at these warm-up sessions by a person professionally trained and experienced in both theatre and public speaking techniques, has proved valuable in getting the staff members to project their voices so that they can be heard easily throughout the auditorium, and to put more life into their discussions. The low, confidential voice of the consultation room seems to be an occupational handicap for most mental health workers when they leave their sound-proof offices to talk to audiences, whether lay or professional.

Even though each "open house" represents a considerable investment of staff time, we regard the

technique as worthwhile in helping professional and lay persons, who are working with tens of thousands of Philadelphia children, understand some of the basic concepts of present day psychiatry. Through the case discussions we believe theories of normal personality development and psycho-sexual maturation come alive and have far more meaning than would dozens of didactic lectures. The emphasis is on mental *health*, rather than mental illness; on an individual's or a family's *strengths*, rather than on weaknesses. The presentations help our audiences learn what kinds of children should be referred to a child-guidance clinic and how these children and their parents can be helped. They see at first hand that psychotherapy is time-consuming, difficult and expensive. They can also sense the limitations of psychiatric treatment, for we present an occasional poor result along with evidences of treatment success. And, as we had hoped, referrals to the Center have improved immeasurably, both in the types of problems involved and in the preparation of families for referral to the Center.

Even more important, we believe, these community leaders have been learning how they can function in their own roles more effectively—how each person can develop his capacities to recognize and handle, within his own sphere of influence, the early symptoms of emotional and social problems of the children he sees. For these people represent the first lines of defense in the battle against emotional and mental illness.

A member of the audience asks a question at one of the Child Study Center's open house case presentations. This session was telecast as part of the series, *The March of Medicine.*

Special Child-Health Conferences

When we were organizing the Center's preschool unit 3 years ago, we asked ourselves: "How can we reach out to pediatricians, to public health and school nurses, to nursery school and kindergarten teachers?" They were seeing thousands of children under 6 every day. At best, in our regular clinic setting, we could see only a few hundred each year.

Case presentations, lectures and talks, did not seem to offer a complete answer. Somehow, it seemed to us, they were like trying to help an interne learn how to remove tonsils and adenoids or to give a transfusion by having him listen or watch. Just as an interne must learn by doing these things himself we thought, pediatricians, and nurses should have some sort of "on-the-job experience" if they were really to understand some of the basic concepts of personality development and mental health and were to use them in their own work with young children.

Should we go out to the existing child health conferences in health centers and hospitals and work in collaboration with the pediatricians and nurses? We could see possibilities in this. Short periods of treatment, we thought, could produce effective results even in mothers and fathers who seemed severely disturbed or who were having difficult marital problems. In the child health conference we could consider the parents' problems in relation to the child.

Dozens of these child health conferences, held regularly every week, could offer ample material. But was this the setting in which we could accomplish most? There is a rush-rush atmosphere in every well-baby clinic. The pediatrician and the nurses are pressured into seeing everyone who comes, to do the best possible job under trying circumstances, and to finish in time to move on to other duties. The average period spent with each child and mother is seldom more than 5 to 10 minutes—hardly enough to do more than a cursory physical examination, prescribe a formula and give the mother a few hurried answers to some of her questions. Moreover, didn't most of the children involved end their contacts at the child health conference by their second or third birthday, just when some of the problems in which we were most interested would begin to emerge? Finally, we thought: "Why not bring the child health

conference to the Child Study Center?" And out of this our modest pilot program was developed.

Our plan was to invite 4 pediatricians and 4 public health or school nurses to join 4 of our staff psychiatrists every Thursday afternoon for 6 successive weeks for a *special child health conference*. The pediatricians and nurses were to refer to this special clinic children whom they had seen in regular child health conferences—children under 6 who were showing some signs of emotional stress in their daily lives through feeding problems, sleep disturbances, bowel and bladder training difficulties, excessive thumb sucking, masturbation, overly aggressive or withdrawn behavior, or other problems. We asked for children with mild problems, from relatively stable families, and we wanted only families who were motivated toward seeking the kind of help we had to offer. A tall order!

Thursday Teams

It took 5 months and countless talks with nurses, pediatricians and others, individually and in groups, before we got the first conference under way. This was nearly 3 years ago. Since then we have had 14 special child health conferences, each consisting of 6 Thursday afternoon sessions, with 4 "teams" participating. They have been the result of cooperative effort with pediatricians and nurses of the Philadelphia Department of Health, school nurses and physicians of the Board of Education and pediatric residents, nurses and social workers of the Departments of Pediatrics of the University of Pennsylvania and the Philadelphia General Hospitals.

A "team" now includes a pediatrician, a public health or a school nurse and a child psychiatrist, along with a medical student and a social worker or psychologist, with never more, but seldom less, than 5 members. Each team meets in a separate room, talking informally with the referred child's mother or father—or both in occasional joint sessions—for one hour every week while the nursery teachers work with the 4 children and observe them as a group in the nursery playroom. After the sixth meeting the families are sent back to the referral sources, along with a summary of the team's impressions and recommendations. Every 6 weeks a new special conference is organized with four new teams assigned for this on-the-job experience, working with four new families who have been referred for this limited goal service.

The teams meet together as a group for the first hour of each session, beginning at one o'clock, with the Center's psychiatrists taking turns in leading didactic discussions of topics of general interest, focusing on problem areas in the personality development of children in the prelatency stage of development. The teams then meet separately for a 15 minute discussion of their individual case prior to the session with the parent or parents.

For the first few minutes of the initial session with the parent, before the child is introduced to the nursery group, the team sees the child and parent together. The team interview begins with the pediatrician getting from the mother what is considered a good pediatric history. Most often he accomplishes this through a series of rapidfire questions and answers in not more than 5 to 10 minutes, just as he is accustomed to do in his office or clinic, and then looks hopefully at the psychiatrist to take over. The nurse, who usually has made a previous home visit to gain first-hand impressions of economic, social and cultural factors, encourages the parent to develop the story further, with the goal of bringing out some of the parents' feelings. By this time, the psychiatrist becomes an active participant, going back to elaborate on some of of the leads which the other team members may have missed.

The psychiatrist tries never to dominate the interview, but attempts to draw in the other team members so that all participate more or less actively during each hour. However, it is his responsibility to guide the session so that this will be a helpful experience for the parents. Should a fellow team member probe too deeply or if the transference and counter-transference, positive or negative, threatens to get out of hand, he steps in.

Of course, the individual and collective relationships that develop between parents and team in these group interviews are different from those in the traditional one-to-one relationship in psychotherapy. Surprisingly, however, some definite elements of transference and counter-transference become evident even when a team of 5 professional persons talks with a lone mother or father and these must be dealt with appropriately. Because the sessions are limited in number, the team members are more active than is customary in child guidance clinic practice. But while suggestions and advice sometimes are given, therapy is mostly nondirective and child-centered. With the father included whenever there is a father in the picture, attention is focused on both parents' difficulties as they relate to the child's problems, rather than solely on the mother-child relationship.

Even though the treatment goals of the sessions

are limited, it has been gratifying to observe satisfactory results in many cases. If we had only "simple" cases, we could expect favorable changes to occur in most families changes in the family relationships which will lead to a happier family life for the child, his siblings and his parents. But getting the "simple" cases for the Special Conference has been our most difficult problem.

Unfortunately, most pediatricians and nurses either are not concerned with the milder problems, or are not sufficiently aware of their potential seriousness, to think of referring for help families whose problems are not extreme. These professional workers are concerned, however, about families which show signs of severe emotional disequilibrium. In spite of our attempts to screen cases, some very disturbed families get into the Conference—cases which do not represent an ideal referral even for the more extensive therapy given in the child guidance clinic. Nevertheless, the teams learn through the failures as well as from successfully treated cases. Quite often they refer families to other community agencies—to the department of welfare, a marriage counselor, the family service agency or to a psychiatric clinic.

For the final hour each Thursday afternoon all four teams meet together along with the nursery teachers, but without the parents, for a case discussion at which the director serves as moderator. Each team is allotted a full hour for its case and an additional half hour at one of the final two sessions of the Conference for a follow-up. Here problems of communication must be solved so that this heterogenous mixture of professional people can understand one another. The psychiatrist and the pediatrician particularly, learn to talk simply, at the level of those around them.

A Learning Process

It is always an exciting experience for us to observe changes in the pediatricians, the nurses, the nursery teachers, the medical students and others who participate as members of the four teams. Pediatricians often change from their rapid gunfire, questioning type of interviewing to a relaxed, less hurried and more psychologically-oriented relationship with the parents.

One pediatrician said recently: "For the first time, I learned to listen to the patient, giving guidance and support, rather than just asking questions and telling her what to do." Another wrote: "I can recognize now what problems I can handle and which ones need the help of someone with more experience."

Children in the nursery school at the Child Study Center, Institute of the Pennsylvania Hospital, prove that cooking can attract boys as well as girls. The nursery school gives the Center's staff opportunity to observe "normal" children.

Another reported: "I gained understanding for the first time about the child's symptoms reflecting problems within the total family; and learned that to help the child, much more is needed than a list of directions dealing only with the alleviation of symptoms."

However, a few pediatricians, in spite of our efforts, remained resistant, fearful or somewhat threatened, unable to change as the result of their brief exposure to psychiatric concepts in this Conference.

The nurses also have varied individually in what they learned. On the whole, most of them have seemed eager to have this learning opportunity. The majority of those who have participated have used it well, both during the Conference and, subsequently, in working with their other patients.

One nurse wrote: "While there was no intent to suggest that the novice practice psychotherapy, the nurse learns in this Conference that the person comes first, not the actual problem or symptom. She also learns that sarcasm, ridicule, or disapproval should never be demonstrated in remarks, general attitude or even facial expression; that praise or blame can be used at the proper time but must always be offered judiciously."

The child psychiatrist, too, learns a great deal from this experience. He learns to work with professional workers from other fields, gaining immeasurably from these contacts. He sees different kinds of cases in the Conference than in his average clinic caseload.

Working as a member of a team, instead of as one individual in a one-to-one relationship, is a new experience for him, and a very leveling one for any omnipotent feelings he might have. Furthermore, with only six sessions with the parents, instead of the indefinite number to which he is accustomed, he learns to sharpen his focus in understanding the child's problems in the context of the total family situation and his techniques in helping the family to deal with them.

After 3 years, the special child health conference has become a well-established part of the Center's program in preventive psychiatry. There are still many questions to be answered and problems to be solved in regard to it. More careful follow-up studies are needed to evaluate scientifically its effectiveness, both for the families seen and for the individual team members. Just as with the open house case presentation, this technique is a time-consuming activity but, in our staff's opinion, extremely worthwhile—both therapeutically for the families selected for referral, and as a learning experience for the professional people who are participating.

The Center also sponsors an annual series of four "Tuesday Evenings at the Child Study Center" which provides lectures, panel discussions, mental health plays and movies for a larger lay and professional audience. While fund-raising is part of the goal of these forums, their primary purpose is to supplement the Center's program in community mental health education.

During the past year the Center organized four separate discussion groups for nursery school teachers and day-care center personnel, each group of 10 persons meeting weekly for 1½ hours for 10 weeks under the leadership of a senior staff member. While this project focuses on child-teacher relationships and the recognition and handling of early signs of deviant behavior in young children, it puts to use group psychotherapeutic techniques in order to encourage the expression of feelings and interactions among the group members as well as in their own work settings.

We believe that the Center's activities in mental health education, with its emphasis on reaching out to persons who work directly with children, has possibilities for indirect, positive effects that stagger the imagination. We are also convinced that reaching out is the direction which child guidance clinics must take more and more actively if they truly believe that "prevention is better than cure."

Many parents will continue to bring up many children in all sorts of different ways. Indeed it is difficult to see how any kind of communal upbringing, however benevolent, could provide the excitement and the tension, the ups and the downs, which are inseparable from ordinary family life. The quality of love, which is essential in good parents, begins with love of the pair for each other, and with love of the idea of having children—not in order to justify a marriage, or even to cement its bonds, but as part of the job as a whole. Children who are the natural outcome of love will be loved as much when they are bad as when they are good (or even a little more).

The tenderness felt towards young children . . . will allow a baby to enjoy its body peacefully in relation to its mother's body and so come to learn the right use of tenderness at a later stage. The older child who fights his parents is engaged in a wholly human activity, in which he explores a great range of human emotion in miniature. He cannot be trained to behave without a quiet place in which to pursue this rehearsal of the real stuff to come. Indeed, what he experiences *is* the real stuff, but he is not expected to stand or fall by the results, as he will have to later in his life.

"*Parents and Children Yesterday and Today*," *Mildred Creak, M. D. Land, F. R. C. P., D. P. M.* The Lancet, *July 31, 1954.*

What more do we need to know about delinquents? An advocate of practice-geared research describes some . . .

RESEARCH NEEDS IN THE DELINQUENCY FIELD

FRITZ REDL, Ph. D.
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PEOPLE OFTEN CHARGE large government research agencies with being clogged with red-tape, overcautiousness, and traditionalism, and give the credit for courage in pioneering to the small, informal community project.

This simply does not jibe with the tradition of pioneering in disease entities which is a part of U. S. Public Health Service history.

The trouble I have is not with creating an urge in people in government to pioneer but with convincing the general community that research in the field of delinquency is as important, broad and complex as research in any of the basic sciences.

Another major problem is to counteract the tendency to look to research as a panacea. Too often the cry for more research in juvenile delinquency, an obviously legitimate demand, is found on closer investigation to stem from a vain hope that the development of a small project here or there can substitute for needed action and guarantee a final solution of the problems we face.

Flight From Action

The illusionary character of this outcry is apparent whenever a group of citizens demand increased research in delinquency and in the same breath ask that funds for service be cut.

Several hundred million dollars could be spent right now without wasting a penny of the money, for what we already know needs to be done. Nobody has to wait for further research to begin filling in the large gaps in our incredibly inadequate resources.

In every community there are hordes of youngsters whose problems are not new to us. Nor are the kids. They are known to dozens of welfare, counseling, service agencies; to courts, probation officers, teachers, neighborhood organizers. Thick folders of case history material lodged in numerous green filing cabinets tell their stories. Many of these children have had rather thorough "work-ups" with psychologists, social workers, psychiatrists, physicians and so forth. Our trouble in dealing with them is not that we do not know what they need. It is that, too flabby to support already existing facilities and to create new, improved ones, we do not cope with the terrific load of long-accumulated need.

Research suggestions which have their source in a flight from action can easily be distinguished from the genuine. They usually are poorly designed and do not receive solid, long-range financial and other support. To begin with, they are meant to last only as long as the dangerously aroused community interest in "doing something." Once the wave of public excitement is over, such research can be easily forgotten, discontinued, or written up for somebody's file.

Escape Into the IBM Machine

When a community suddenly turns its spotlight on its problems with youth, we researchers are in a tough spot, too.

The layman suddenly pounces on us and gleefully asks us the embarrassing question:

"Now, look here, the youth of our Nation is going

to the dogs. Just what are you guys doing about it? How about leaving your wise theories for a minute and giving us the answers, for a change?"

Research in this area has been neglected or nonexistent for years. The sudden discovery of its potential contribution hits with a heavy blow. No wonder the research specialist looks for an easy way out.

Most of the research specialists—for more reasons than could be listed here—have been busy with something else; not with the juvenile crooks, under-aged gangsters, and child schizophrenics for whom they are suddenly supposed to find a solution.

In fact, many of the most prominent contributors to the methodology of research have rarely spent much time with either normal or pathological teenage hoodlums. They haven't sat in a school room in a slum area for many years; haven't had to squelch a riot in a model community youth center.

They know little of what it feels like to be a well-meaning house matron in a detention home that was built for 48 children, houses 104, and has neither space nor staff to do even the most basic things—a house matron who is supposed to survive without punitiveness toward a bunch of bored, restless, and, to varying degrees, sick recalcitrants.

So, the layman's embarrassing question catches the research specialist with his complacency down. Expected to give an answer to something he has not been asked about for a long time, he scurries for security to the things with which he is most familiar. And the public's demand for more knowledge about delinquent youth is met by fancy research designs, based on the best of our scientific arithmetic. Getting busy at once, he starts counting.

We research specialists have all learned to count, and to look for "countables" all over the map. We ask ourselves if it would help if we knew how many kids living in what kind of apartments do damage with what kind of props and how often a year, or if we looked at the families who kicked these kids out and found a new "correlation" between "environment" and "crime."

I am not making light of the very important tools of statistical methods or quantitative studies. I am only bemoaning the fact that we use the best tools we have, when under duress, to hang on to the tools themselves rather than to ask what kind of insight needs most sorely to be gained.

The first question thus becomes:

"What could we use our research tools on?"

It should be:

"What do we need to know about youth in order to tackle delinquency?"

So we measure and weigh and come up with more Chi Squares if we happen to be statisticians. If "personality testing" is our main goal in life, we give another thousand Rorschachs or TAT's. Or we force a few delinquents to play with our guidance-clinic doll houses—originally enjoyed by the neurotic or phobic child.

All this is good. But the practitioner, who must make daily decisions about child life from his foxhole, has a few additional questions to ask, which will never be answered by this approach. How about listening to him for awhile?

The Cry for Practice-Geared Research

The practitioner—by whom I mean all those who deal directly with delinquents (including teachers and parents)—has an old complaint.

He is ready to pay tribute to the long-range usefulness of our fancy formulations, terminology and curves. He politely admits the research expert probably produces a lot that is important.

His complaint is that the research expert does not answer the questions *he* asks.

And of course he is right.

On the other hand, the research expert has a complaint of his own. It is that the practitioners are asking him the wrong questions. The practitioners do not understand how complicated research is, and their demand for simple results, easily and preferably cheaply applied, is nonsense, he says.

And of course he is right.

Just as in other areas, there is a real place for basic research around delinquency. While seemingly far removed from the rough realities of daily life, basic research eventually produces more blessings than many of the seemingly practical suggestions of the common sense approach. Modern physics has certainly proved that there is more practical reality in some of the mathematical formulae of the theoretical physicist than the public might have expected before The Bomb was exploded. The same may be true in the social sciences.

The justice of the complaints of both the practitioner and the research expert does not rule out their working in partnership on some parts of the job. There are plenty of questions concerning practitioners in areas that right now are at a stage in which they could and should be tackled by basic research.

Assume that I am a probation officer, judge, or court worker, or that I am busy in a family service

agency or child guidance clinic as a psychiatrist, psychologist, or caseworker.

Assume that I am a group worker planning a camp or club group for youngsters of high delinquency risk.

Or that I have to try to keep a bunch of restless eighth graders interested in staying in my school room.

Or that I am a parent worried about what I would have to do if Johnny started running with the wrong crowd.

What kinds of things would I need to know in order to answer the questions that arise, and how could the research people help me to know them?

In all of these instances practitioners would benefit from a much more precise description of what forms of behavior indicate a serious disturbance and what things youngsters of certain ages might be expected to do which are just part of their developmental phase and of nothing else.

Some Suggested Projects

I recently compiled a list of 21 research projects which could be undertaken today, with equal fascination for the basic researcher and the practitioner. They will not answer all the practitioners' questions, but some of those questions should be answered by the concerted efforts of the practitioners themselves.

Research, however, could help with such areas as these:

Assessment of Treatment Needs

Decisions whether a child should have a foster home, an institution, outpatient therapy, a psychiatrist, or something else are still made on the most amazingly mystical or at least non-explicit basis. Worse, scientific lingo is amply used to disguise the fact that actually value judgments or personal preferences for traditionally accepted or rebelliously preferred treatment methods usually govern referral, intake, and exclusions.

It is time that a scientific machinery of concepts is developed which can bring order and real prognostic acuity into the whole process of placements or referrals to therapy.

Behavioral Influence Techniques

Psychiatry has been inclined to be so vocal about the importance of the relationship between people that the importance of just what people *do* to influence each other has been neglected. Even if Papa loves Mary and Johnny adores Mama, just what they all do to wheedle pocket money out of each other, or just what the old man does when Mary has a tantrum, also has a lot to do with the developing pathology.

In residential therapy with delinquents, the hygienic manipulation of surface behavior becomes especially important, but the advice-giving psychiatrist is usually hampered even in out-patient work. Organized research on the effects of all influence techniques is of the utmost urgency.

Are We Sure We Know Why They Can't Learn?

Severe learning disturbances, especially in the area of reading, are a frequent concomitant of all types of problems we get under the label of delinquency. The general approach to this is too glib and either-or; either remedial teaching ought to fix up the cognitive mess while the psychiatrist fusses with the souls, or it is impossible to help youngsters learn how to learn until their basic personality disorders are taken care of.

I have a hunch there is a lot more to it, and a wide range in between. Organized research is badly needed on the inter-locking of basic pathology with cognitive disturbances, on new methods for a frontal attack in some of these areas, and even on the whole question of what is basic to what.

Social Perception

A few years ago in Detroit, we hired a bunch of boys to put on a "club meeting." They had a script and one boy acted out the role of the leader, and others, followers, and others disrupters in the "club meeting."

We also hired another bunch of boys to look in on this club meeting through a one-way screen and tell us what they saw.

Some of the observers saw the pecking order—how all the group was dependent on one boy. Others only saw a bunch of boys playing with a pop gun. They had no social perception of the factors involved in this group process.

We have learned that some organized delinquents betray through their amazing manipulation of people an unusual amount of social perception. They have the kind of perception that a nightclub entertainer has to have. Their main trouble is that they make the wrong use of it. But some other youngsters simply do not know how to assess what goes on in a group and get into trouble on that account.

The studies on social perception now underway

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are only crude beginnings; and the general statistical studies of widely mixed perceptual issues are of no value to the practicing clinician. Investigations first need to be made into what it is relevant to study the perception of. For the treatment of children with delusional hostilities and other perceptual and conceptual distortions so frequent in the delinquent population, a concept of social perception with much higher proximity to clinical issues and group processes must be designed.

What Is Right With Them?

What does constitute *progress*, *improvement*, or partial or total *cure* in a therapeutic situation?

The difference between improvement that is therapeutically premature or even false and real improvement is theoretically clear, but standards for evaluation are not developed on any adequate scientific basis.

Even the very terminology and conceptual machinery needed to observe positive functioning is underdeveloped. Most people who observe a temper tantrum have no trouble describing what happens, but the observer who is confronted with a stretch of conflictless behavior in a patient usually slides back into evaluative generalities, ignoring the rich and complex processes which are making things go, and which are studied so carefully when the machinery breaks down.

An organized research attack on this is of great importance and reaches far beyond the psychiatric field.

Group Compositional Problems

We already know that a treatment-negative climate is produced if we expose extremely shy youngsters to youngsters who need to act out their behavior problems with unusual violence. The result in such a situation is to increase the internal problems of the shy child, who may be either frightened, or lured into behavior foreign to himself, and who inevitably will have his guilt feelings intensified.

We also know that children who steal on a fantastic basis—for instance, the kid who swipes a picture of his counselor's boy friend and buries it in the sand—cannot survive in a group of organized delinquents. In the first place, organized delinquents have too good a personnel department to let in "psychos." And if the fantastic stealer gets into such a group, he will be mercilessly exploited, even though both kinds of youngsters are thieves.

What we need to know, within extremes such as these, is which pathology gets in the way of treatment of other pathologies when treatment takes place in a group setting.

Is there a "law of optimum distance" within which it is safe to treat children with varying pathologies in groups? How do you measure this distance? What specific characteristics should we look for before a group is organized? How much do different styles of therapy, different settings, different group sizes, affect the problems of group composition?

Programing

Some games have built-in safety devices which successfully handle the kinds of internal problems that the games produce. In Three Deep, for instance, the kid who moves outside the circle, and, while there, is chased by another kid, has the protection of the circle to return to when he has had enough.

But for some children, Three Deep builds up more excitement than can be contained in the game, and the results may be disastrous. In some other games, there is no built-in device against mounting anxiety.

Some games involve choosing sides, and most children can handle the temporary antagonism that being a part of one side, opposed to another, creates. But the very anxiety of being chosen, or not chosen, is too much for some children to bear. For others, too much hostility is created when one team fights another. For children such as these a different game structure needs to be selected.

In general recreation programs, we feed games to the kids and then pick up the pieces when the group-produced hostility, anxiety, or acting-out gets out of control. In the treatment of disturbed children, we must get beyond this. We need a psychiatric estimate of the potentials and danger spots of games and other activities used. Which games have what security devices to produce what results would be part of an organized pharmacopoeia of games. Indeed, this pharmacopoeia should include programing for anything children in group treatment do during a day or a night.

What people do with or to them, what props these people rely on, what vehicles they use to communicate with each other: all these things have real impact on the balance between impulses and controls both within the patient and the patient group.

Personnel and Training

All these research projects have fairly obvious applications for the practitioner in his foxhole. Of equal validity, although of more long-range applica-

tion, are two needed sets of answers in regard to personnel:

What Traits?

All the wonderful measuring instruments put together do not yet do the trick of testing for the specific traits that make for a good worker with disturbed children. In fact, we do not even know which brand of our own childhood neuroses predestined us to be especially good as a psychiatrist, a nurse, a group worker, or what not.

We do know that some people who work extremely well with very disturbed children very often have had a number of problems themselves, either internal or external, in growing up. Nevertheless, it would obviously be wrong to insist that people work best with unstable kids if they are unstable themselves. For there is a point beyond which one's own previous or present problems, rather than being a resource of experience to draw upon, get in our way and lure us into using the children as mops for our pathological needs.

Organized research into the question of trait syndromes and their relationship to specific professional performances in this field is still not developed. Good testing instruments for personnel selection cannot even be dreamed about without more knowledge along these lines.

Training—For What?

Any clinical specialist suddenly thrown into the job of consultant to an institution for delinquents may have had very adequate training so far as his own specialty goes. He may still find himself way out of his depth when he is suddenly expected to develop inservice training programs for the so called "auxiliary fields."

Yet is it *he* who is asked to tell the others what they ought to know. The temptation to feed to houseparents, group leaders, attendants, and others some watered-down versions of the concepts and knowledge that were considered an important part of his own training is as widespread as it is disastrous.

An organized study of the actual training needs of people who perform specific tasks in the lives of children is a prerequisite even for the training of those who are later to train others.

Thinking Straight About Delinquency

Psychiatry has, for the most part, focused on the feelings, emotions and attitudes of people toward delinquency and delinquent children, figuring that little gain can be made by straight scientific knowledge unless those feelings, emotions, and attitudes can be changed.

When one is concerned with influencing larger parts of the population in the direction of wiser community planning for vulnerable children, one needs to know also what the current "thinking pattern" on the delinquency issues is of the public at large, as well as of parents, teachers, judges, and others who come in contact with them.

In order to know what facts and arguments would be most convincing, organized public opinion studies need to be made, which are specific enough to tease out concrete patterns of faulty reasoning, special areas of fact blindness, and the like. Such studies are as important for those dealing with delinquency as are those in the field of physical disease for the public health educator.

In Summary

These are some of the research problems which I believe should claim our attention. Those I have listed are meant to be primarily related to issues for which the field of psychiatry has a strong affinity.

Many other equally important research issues, especially those of larger community impact not primarily psychiatrically geared, have not been touched on here for purely practical reasons.

It seems to me that the answers to any of these questions would be dear to the practitioner's heart. The answers will not come, however, merely from the practitioner's daily observations. They require a laborious detour through sheer basic research.

"Only the sham knows everything; the trained man understands how little the mind of any individual may grasp, and how many must cooperate in order to explain the very simplest things."

—Hans Gross, as quoted in Social Diagnosis *by Mary E. Richmond, Russell Sage Foundation, 1917.*

An American project to train child care workers provides observations on . . .

PLAY BEHAVIOR IN DEPRIVED KOREAN CHILDREN

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THE RECENT KOREAN WAR left many homeless children in its wake. Many institutions in the poverty-stricken Republic of Korea (ROK) are struggling to care for these children in the face of great obstacles, chief of them being lack of supplies and lack of training and experience. Fifty-thousand children receiving long-term care in institutions creates a national problem. The United Nations, the United States International Cooperation Administration, the U. S. Armed Forces, and many voluntary agencies have brought in large amounts of money and material aid. In an effort to help institutional staffs learn to understand children and plan wisely for them, the American-Korean Foundation (AKF) and Christian Children's Fund, Inc. (CCF), have cooperated with the ROK Government and the League of Social Workers in a training program.

This program has several phases, including leadership courses, courses for child care workers, and follow-up work. The leadership course for superintendents always precedes the child care workers' course, which primarily attracts housemothers. All of the courses are given on a provincial basis in some orphanage which seems to lend itself readily to such a program. Although the principal teachers in the courses are two American representatives of AKF and CCF, Korean personnel are also used whenever possible.

In the first short, elementary courses, the purpose is not primarily to impart specific skills and knowledge, although some of this necessarily creeps in. Rather, the aim is to start the trainees thinking about the needs of children. In a society where the individual traditionally derives status solely from his family position, it is sometimes difficult to get even a professional social worker to take a real interest in a child without family. Once this is achieved, however, the program proceeds on the theory that every attempt should be made to encourage the Korean people to solve their own problems in their own way, though some American methods might successfully be adapted to the Korean situation. While continuing guidance may be necessary to keep the focus on the needs of all children, the Korean orphans must be reared to become good Korean citizens. The Korean people can best know how this is to be achieved.

Poorly understood words and phrases can easily become connected with specific, irrelevant American ways. For instance, one orphanage considers itself a model of American democracy because children have bread for breakfast and are called by Western names. Its big attraction is the lovely oven for baking bread. This is an exception, of course. Ordinarily, the Koreans are very pleased to learn

*Rose Alvernaz of the American-Korean Foundation is the author's colleague in the training program described here.

that an American agrees that it is good for the children to have Korean rice and soup and perfectly fine for them to leave their shoes at the door and to sit on the floor for meals.

Content of Courses

The content of the courses varies somewhat according to the nature of each training group. The trainees discuss the social implications of their work, the nutritional needs of children, sanitation, medical care, educational needs, and leisure-time activities. During all of this, they are encouraged to think of what it means to a child to be deprived of his family. Some aspects of administration also enter into the discussions, and, of course, the ever-present behavior problems. The course for child care workers has work-shops in play materials for children as well as periods of observation of pre-school children at play.

Since neither of the two American teachers are skilled in speaking or understanding the Korean language, they must carry out nearly all of their work through interpreters. While this is a real handicap, it also brings to light interesting avenues for communicating the ideas and feelings involved in the good care of children. One of the most rewarding of these is the children's play group which is part of the child care workers' course.

The play groups serve several functions. In the first place, they provide for the possibility of observation. Each trainee observes one preschool child for at least 1½ hours on 6 successive days and writes a study of his behavior. Secondly, the spontaneity and variety of behavior in preschool children inevitably provides much material for discussion. This reinforces teaching in more formal lectures. The way in which the child's history and physical condition affect his present behavior is well-illustrated in the play groups.

Thirdly, besides opportunities for learning about the behavior of children, the play groups provide a setting in which trainees can see that children react to adults and to each other in relation to the way the adults handle them. The trainees are always most impressed to find that the foreigners, who know only a few words of the native language, can be so effective in working with Korean children. During the course at Pusan, one little girl talked incessantly to one of the American teachers. Neither could understand the other, but the following day the child told the superintendent about the conversation. When the superintendent asked the little girl what the American had said, she replied, "Well, she told me that she likes me very much and I should come back to visit her tomorrow."

Example in Seoul

A course for child care workers recently given in the city of Seoul had an enrollment of 33 women. They were housemothers or matrons from 21 children's institutions within the city. The age range

Four Korean orphans in a child care center during the training course for personnel described in the accompanying article. *Left,* the little girl swinging with her doll on her back, follows a common pattern of playing alone. *Center,* observers take notes as a small boy hoards his ration of puffed wheat. *Right,* the fascination of building with blocks brings two children together.

of the trainees was 18–50 years, but most of them were in their twenties. All but two had completed at least secondary school education; several had had college courses. In their own institutions, some had responsibility for a group of only 5 or 6 children whereas others had 25 or 30 children to look after. Some of the matrons had supervisory responsibility for 150 to 170 children. The age of the children under the care of these women included the whole range from preschoolers through 18-year-olds.

The Setting

The orphanage where the course was given did not at that time have an adequate program for young children or even a plan for one. It had only recently taken on, for the first time, a housemother whose only responsibility was to care for the preschool children. This woman had had no previous experience with groups of children. However, she and the rest of the staff of the orphanage were extremely interested in the play group. Though at first they did not completely comprehend what the teachers were trying to do, they assisted in every possible way. Previous to the course, the American-Korean Foundation had given advice and assistance to the orphanage. The cooperation of the superintendent and staff in the training program was evidence that their confidence had been won by a skilled social worker who had a deep respect for the culture and integrity of the Korean people.

In this course, the children in the play group were exceptionally deprived. Of the 12 children, 8 were new to the orphanage. The exact birthdate of each child was not available; they were 5, 6, and 7 years old by Korean count, which might be anywhere from 1 month to 2 years less than by the Western way of counting age. The one little boy who was 4 years old on the records seemed to be about 34 or 36 months of age.

Most of the new children came from the city receiving home which was not yet well set-up for the care of young children. It is very doubtful whether they had received much individual attention. Certainly, they had not had access to many playthings. All but one of the children were underweight and malnourished. In fact, they were alarmingly thin. Many of them had sore eyes.

Play materials for the course were adapted from standard American nursery school equipment. They were found on the Korean market or especially made when necessary. Because Korean institutions are not financially well off, an effort was made to use only basic durable equipment. Furthermore, culturally structured materials were made in Korean prototypes. Dolls resembled Korean people, and doll dishes were like Korean dishes and pots and pans. Play materials included unit blocks, trucks, push toys, dolls and doll dishes, paper and crayons, sieves for sand play, and balls. The orphanage already possessed two sets of swings, a jungle gym, and a sand box.

From the first, the most popular of the playthings were the push toys, balls, sand, crayons, swings, and dolls and doll dishes. Drawing pictures was mostly in the experimental stage, with very little representation. In their doll play, the children loved to tie their "babies" on their backs as good Korean mothers do. There was always great competition for possession of the dolls, but three of the girls would sometimes play together peacefully with the doll dishes for long periods of time.

None of the children was interested in climbing the jungle gym. Once it was possible to coax the strongest lad to climb as high as the second rung.

When the children in this group first encountered the permissive play situation, they had no skills at their command for adequately meeting the demands made upon them. Besides behaving generally in the manner of 2- to 3-year-olds, they exhibited many other symptoms of maladjustment—temper tantrums, long spells of crying, hoarding toys, hoarding food, inability to play together or to participate in organized play, and seeking to be the exclusive object of the adults' affection. One child showed an extreme fear of foreigners.

Although emotionally at the level of two-year-olds, these children showed the intelligence and memory of children their own age. Some of the things they would do to each other seemed really vicious, such as pushing an unsuspecting child off a very high place long after the quarrel had been "settled." The teachers had to be on guard constantly to prevent severe physical injury.

Signs of Progress

At first, there was no sharing or give-and-take in the children's play. The children could not tolerate even the slightest deprivation. With the continued presence of predictable, interested adults, they came to understand that sharing toys and teachers did not mean total deprivation. Consequently, their play became increasingly constructive. While at first they were completely unable to build with blocks, they began doing so the second week of the 3-week

observation period, concentrating on carefully built, rectangular, enclosed structures. After another week, the children discovered that one child could sit in the big toy box and line the box with blocks, while the others put on the roof. This was the source of great fun and the most cooperative achievement of the entire session. Such play took place at times when there was little aggressive feeling among the children.

After the children played together for about a week, their practice of hoarding toys diminished greatly. Whenever a new kind of plaything was introduced, however, the entire learning process had to be repeated. Once when the teachers brought in some wooden spoons for sand play, the temper tantrums and crying increased considerably.

Although the children's regular meals included nutritious canned foods, it seemed advisable for the play group to have a mid-morning snack which could be provided in quantities of "a grand sufficiency." The best inexpensive food available for this purpose proved to be puffed rice. When this was first given to the children, one doll-dishful after another, they carefully folded the first allotment in their handkerchiefs, and pinned them carefully onto their shirt or dress. The next bit they stuffed into their pockets, and finally, when all crevices were bulging, they ate and ate and ate until there was no more. As time passed and large amounts of puffed rice appeared each day, hoarding lessened to the point of almost completely disappearing.

Change in Housemother

Improvement in the behavior of the children was paralleled by a change in attitude on the part of their housemother. At first, she seemed unable to understand the permissive play situation; she could not comprehend that any good could come of permitting the children to cry hard or to leave the group when they were angry. In the morning, the children frequently showed generalized feelings of aggression that could be attributed only to the manner in which they had been handled before the play session started. Once they dissipated these feelings through temper tantrums, they would settle into constructive play. However, they would rarely approach the housemother when they needed help and would never sit on her lap or show other signs of affection. This continued for a week, despite several interpretative conferences with her. Then one day, she seemed to understand what was happening. The frequency and intensity of the children's tantrums had already diminished; with the housemother's change in attitude, they became practically nonexistent.

Some Children

Chol-Soo, a very thin 5-year old, had many temper tantrums. One day he had four violent tantrums within an hour and a half. He was always hungry and cried for money so that he could buy food. On one occasion he searched the pockets of a visitor, all the while whimpering and asking for money so he could buy something to eat. He had no notion of property rights and could not understand that sharing toys did not mean total deprivation. He had to have every piece of the three sets of doll dishes or he would throw them all away.

One morning, Chol-Soo had pronounced feelings of aggression towards a docile little girl who had come to the orphanage just a few days before. Any toy she happened to have he would take from her, hitting her very hard. It finally became necessary to remove him from the group altogether. He drained off his feelings with a violent temper tantrum. After being held by the teacher for about 15 minutes, he gradually became interested in playing. Then he began a period of very constructive play.

When children became involved in conflict, the temper response often seemed to become detached from the original trouble. In-Sook, for instance, would exhibit her displeasure through long periods of crying or sullen silence. Once started, her rhythmic crying or muteness might last the entire morning. On one occasion In-Sook went into a long period of sullen withdrawal after being overlooked when cookies were passed. She took off all her clothes and refused to come inside to play. After sitting on the teacher's lap for a long time, she voluntarily put on her clothes and finally accepted the cookies belatedly offered her.

The next day, when the housemother gave the children some soda crackers, In-Sook refused hers because she was not first. Then she began a period of rhythmic weeping broken only when the teacher took her along on an errand back to the main building, carrying her all the way. There she quickly revived, put on her shoes, held the crackers herself, and carried puffed rice back to the play group.

In the first play session, Oak-Ja screamed and covered her face when she saw one of the Americans. A few days later, she only covered her face and then was able to continue playing in the group, although she kept her distance from the foreigners. One morning, she told the Korean teacher that she was

no longer frightened of the Americans. Her care in avoiding them, however, indicated that her statement was mainly an attempt at reassuring herself. Very slowly she gained confidence in the foreigners. At first, only the Korean staff could give her cookies and crackers or puffed rice. After a time, she would approach the foreigners herself. Eventually she became their fast friend.

One little girl at first seemed well adjusted in comparison with the others in the group. In the first play sessions, she would sing and play happily with the doll dishes, and she would draw many pictures with the crayons. As the course progressed, however, it became apparent that she had deep-seated hostilities which did not at first show in her behavior. As the others learned to play together, she became more withdrawn from the group and would sometimes hang around open doors, muttering to herself. No doubt attention had been concentrated too much on those with more overt problems.

Three of the children seemed happy and relatively well adjusted throughout the 3 weeks. One of the older boys, particularly, seemed to enjoy himself and others. He was extremely thin and had sore eyes, too, but there was always a sparkle in them and a big grin on his face. He seemed to enjoy everything he did and put his whole heart into it. If one of the less mature children insisted on having his toys, he would shrug his shoulders, as if to say "Why make a big fuss?" and off he'd go to amuse himself with something else.

The Lessons

Although this experience illustrated that severely deprived children are likely to be very retarded in social and emotional development, it also demonstrates that a change in external conditions and method of care can facilitate vast improvement in even a short period of time. Moreover, the changes in attitude of the housemother and others on the staff of the orphanage showed that even a short period of training and observation can be effective in influencing the behavior of adults toward children.

One of the drawbacks of such a course is that the short period of time does not permit 30 trainees to have supervised work with children. Still, the observations and discussion groups call many aspects of child care to their attention. At the end of the course, the teachers always had the feeling the trainees had absorbed all they could for one session.

In the observations, the first problem is to get the trainees to write what they actually see rather than what they *think* the child is like, or what they wish he were like. Sometime a seemingly innocuous lecture can be detrimental in this respect. One day the teachers stressed the importance of adults looking for the positive aspects of the child's behavior. In the next day's discussion, the trainees insisted it was their observation that Young-Ja was a dear sweet child. Actually, she went about hitting everyone in the room!

It takes a long time for the trainees to become realistic in their observations; but once they begin to take this approach, they are amazed at what they find. For instance, those in the course at Seoul began to think of new ways of managing crying children. The traditional Korean method is to stop the crying as quickly as possible, regardless of the cause of crying or the educational consequences. They are apt to go to opposite extremes: the child may be commanded to stop crying; or he may be given a sweet or some toy he wants. This may have certain values in family life, but it does not offer much to the learning of a large group of young children. In the Seoul institution, where there were so many crying children, many of the trainees' comments indicated they had learned that a kindly, permissive, yet firm, manner is more successful in the long run than yielding to every whim of the child or expecting him to have the capacity to obey a "stop crying" command of his elders.

These concepts have significance for the Korean people, who have experienced profound social change since their liberation in 1945 and particularly since the 1950–53 Korean War. Many of the old family patterns have disintegrated. The recognition of the worth of the individual requires different expression than before, but whether a child eats rice, bean curd and kimchi, or bread, meat, and pickles is not important. What counts is the interest and love of a sympathetic adult. This has been clearly shown in these experiences among very deprived children.

AN EXPERIMENT IN TRAINING TEACHERS FOR CORRECTIONS

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AT THIS POINT in the development of services for juvenile delinquents, personnel training is frequently proposed as one of the important solutions for our problems. Repeatedly experience suggests that the next step in improving services must depend not so much on finding out what we should do as on finding professionally prepared personnel to man the services we already have.

The problems of staffing our agencies with trained personnel are many. Actually very few persons are specifically prepared for working with delinquents, in relation to the number of openings for them in services today. At the same time, many agencies do not have personnel policies and job definitions which would attract and hold individuals who have invested money and time in professional education. A further problem is the lack of agreement within the field of practice and among educators as to what actually constitutes sound academic preparation for various kinds of work in services for delinquents.

Although organizations representing practice and educational bodies representing sociology, criminology, and social work are engaged in efforts to define the training needs for work with delinquents, many unanswered questions remain as to the content of and the appropriate educational auspices for such training programs. A serious aspect of this problem is a lack of teachers who through practical knowledge of the field are able to adapt concepts from related disciplines for work with society's offenders. In the long run, only teachers, working with practitioners, can identify the educational problems, and design the educational policy and curricula.

This lack of teachers for training practitioners has been identified by the Children's Bureau's Division of Juvenile Delinquency Service as one of the major bottlenecks in attempts to increase the number of competent personnel in the basic services for juvenile delinquents. Since the Bureau regards social work as one of the professions which could make a major contribution in this direction, its first jointly planned and jointly sponsored training project was designed to prepare social-work educators for teaching in the field of corrections.

The use of the term corrections in this context will surprise persons who have been accustomed to think separately about work with juvenile delinquents and work with adult offenders. The separation of services on the basis of the offenders' age has been related historically to reforms designed to protect younger offenders from contact with adult criminals. It has stemmed from recognition of the special developmental needs of children and youth and society's greater willingness to underwrite administrative advances for juvenile offenders than for adults. However, in terms of the basic processes of work with offenders, the functions of the services, and the educational approaches to preparation of personnel, these distinctions between services for juvenile and adult offenders do not hold. From the point of view of training, the field of corrections is sociologically and educationally a whole. Within this educational whole, there will, of course, be various specializations of focus. But the overall framework is particularly important in the development of teachers.

The project for developing social-work educators for the needs of correctional services was jointly planned by the Children's Bureau and the School of Social Welfare, University of California, Berkeley as a special enterprise within the School's 6-week summer session of 1956. It brought together 24 teachers and potential teachers of social work from various parts of the United States to study the adap-

tations of social work in correctional practice. With them were assembled a faculty drawn from criminology, psychiatry, social-work education, and correctional practice. Associated in the project were 10 California correctional agencies which provided 24 field placements in staff development for the project's participants. Grants from the Rosenberg Foundation of San Francisco, Calif., and the Doris Duke Foundation made it possible to provide for student and faculty expenses. Staff for the administrative functions of the project was provided by the School, the Council on Social Work Education, and the Children's Bureau. The National Probation and Parole Association was also co-sponsor.

The first task in assembling the participants was to identify those persons in the United States who were equipped to teach social work for corrections and to select from among them the 24 participants who could be accommodated in the project. The process by which this selection was accomplished began with circulation of requests for nominations to deans of schools of social work and to administrators who were known to be interested in professional education for correctional practice. Of the 138 persons proposed as candidates through this nomination process, 81 applied for admission. The selection of the participants from these was determined by the University of California with the help of an advisory committee composed of representatives from each of the sponsoring organizations.

In the selection process, preference was given to persons who were qualified to teach in schools of social work, who had experience both in correctional practice and in teaching, and who had their careers largely ahead of them. Particular emphasis was placed on admitting candidates from schools of social work which reported plans for expanded educational services for corrections. Of the 24 persons admitted, 13 came from faculties of schools of social work; 11 were practitioners interested in teaching.

Educational Design

Since the goals of the project were to prepare teachers, to develop further the theory of social-work practice in corrections, and to try out teaching materials, its educational design included a variety of learning experiences. All participants attended three seminars a week. One was addressed to the social determinants of the correctional system; another focused on social-work methods in correctional practice; the third gave attention to problems met in extending social-work education to professionally underdeveloped fields. In addition to these formal gatherings, one evening a week was scheduled for informal discussion with representative leaders in correctional theory and practice. A special one-day workshop was held with a psychiatrist who had correctional experience. A variety of materials including previously unpublished writings and case records were made available.

In addition to taking part in the academic program, each participant spent 2 days a week on a field assignment in a correctional agency where he worked with a staff group on a selected staff development problem. The staff development problems, selected by the agencies, involved a wide range of service, staff, and administrative issues. These field placements served to bring reality to the problems discussed in seminars, to dramatize the possibilities and problems of the consultant role, and to heighten the motivation for work on theoretical issues. Small group discussions with assigned faculty consultants were scheduled each week to provide the participants with an opportunity for integrating their learning.

Two aspects of the educational design were judged to have been particularly useful when, at the end of the project, the faculty considered the 6-week experience. One of these was the selection of faculty to include several disciplines and approaches: social-work education; social-work practice in corrections; sociology; and psychiatry. The other was the bringing together in one student body, persons from faculties of schools of social work and from correctional practice. Thus, important professional problems in communication were bound to appear and could be worked on, and contributions from the essential bodies of knowledge were insured.

The preparation of the student group for participation in the project was also effective. Most of the students came to the project already moving within the experience. The unusual readiness of the student group, as evidenced in enthusiasm, active interchange with other students, and eagerness to get going, seemed to have resulted from the long period of preparation. Steps in this had included the selection and nomination process, assignments made before assembling the group, and opportunities for communication with the faculty.

Two evidences of sound educational design are the ease with which educational problems can be identified, and the flexibility of means available for dealing with such problems. To a large extent, the project met these tests. Attention to the formation of informal groupings among the participants as

they reflected crystallizing problems of communication, provision of opportunities for individual conferences with faculty, and frequent faculty meetings convened for the purpose of experimental modification of design were components in the adjustment of the program to emerging educational needs.

Educational Problems

Three major problems developed. The first reflected the differing expectations of the project brought by students and faculty. Some of the student expectations were expressed in a demand for large bodies of content even in areas where little content is as yet available. Some irrelevant expectations resulted from the temptation for many students, having their first visit to California, to think of the 6 weeks as an opportunity for exploring a part of the country new to them. On the other hand, the faculty had anticipated more readiness on the part of the students to engage in theoretical pioneering than was realistically possible in the light of the broad areas of professional material to which many of the students were exposed for the first time.

One adjustment made early in the project reflected the faculty's recognition that theory development would have to be primarily a faculty function. The assignment of the full-time consultant from the Council on Social Work Education to the job of theoretical integration, with appropriate minute taking and secretarial help, set up a structure for theoretical development. That the need for such a structure had not been anticipated was but one example of the fact that the roles to be carried by the project staff had been insufficiently identified in the preliminary planning. In a variety of ways, it became evident that too many roles were expected to be carried by individual staff members. The separation of administrative roles from teaching roles and from theory-integration roles seems to be essential for full achievement in a project of this sort.

A second major problem which occupied much of the attention of students and faculty during the first 3 weeks of the project revealed itself as an inability of the students from practice and the students from social work faculties to communicate with each other. This problem emerged as persons from practice became increasingly silent in seminars. It was also reflected in the informal groupings of the student body which crystallized to some extent according to the identification of the students as from "practice" or from "education."

The process by which this problem was met included conferences by the project director and other faculty members with individuals; much discussion in informal session among the students themselves, sometimes with a faculty person present; open discussion in small groups formally scheduled with faculty leadership; and, eventually, open acceptance of the problem and work on it in the seminars.

In these discussions the students revealed the frustrations they felt in their efforts to work at problems together. Students from practice reported that each time they posed a serious practical problem the educators responded by saying "but that is the same in all of social work" and took over the discussion in terms that seemed meaningless for practice. For example, practice people several times attempted to focus attention on the problem of maintaining professional identity on a job which also required the occasional use of certain physical controls, such as detention, or handcuffs. The educators responded immediately with "but all social workers use authority." Since the educators were quicker at presenting their position verbally than the practitioners, the resulting discussion would usually consist of a repetition of current generalizations, rather than an analysis and examination of the problem in the light of principles. On the other hand, the educators felt frustrated because the members of the practice group, less aware of educational problems and formulations, seemed unable to move quickly into professional and educational generalizations.

The discussion of these experiences, first in the small groups and then in the seminars, led to open recognition of the communication problem and conscious efforts by each group to listen to and understand what the others were trying to say. This recognition that representatives of practice and of education have difficulty in talking with each other and that a conscious effort can result in more productive work together was one of the major learning experiences of the project.

A third important problem was the lack of readiness on the part of the students as a group to use patterns of conceptual thinking, either in relation to theory of practice or in educational areas. They were ready to discuss specific experiences or to use broad generalizations which on analysis proved to have individually selected rather than generally accepted referents. For instance, the idea of "host agency" had at least five different meanings to various members of the group, and the frequent discussions of the "generic-specific" issue in social work theory reflected many frames of reference. In addi-

tion there was little readiness to differentiate between the processes inherent in practice and those related to education.

The group's problem with the use of conceptual thinking showed up in the difficulty it experienced in focusing discussion around a "for instance." The practice people frequently were able to state the problem and were somewhat more ready to document and analyze it from a number of points of view, but could not move on easily from there to generalized conclusions. The educators were more quick to classify the problem but had more difficulty relating such classification meaningfully to specific instances.

The need for the group to develop processes of conceptual thinking could only be tackled through a variety of efforts to help them move from specifics to generalizations on the one hand and from a conceptual framework to the specifics on the other. For instance, the problem of professional identity in a field where use of physical controls is essential was finally formulated and documented as to points at which it occurs, and some principles by which the social worker might guide himself in relation to the problem were suggested. Experience in these processes undoubtedly had different meanings for individual students depending on the individual's readiness for theoretically disciplined thinking. The result of this kind of detailed work was that certain aspects of content were more completely explored than others.

Educational Outcomes

The educational outcomes of the project are reported in the minutes of the summary session which included both students and faculty. The students identified progress in the following directions:

1. The significance of studying the correctional field as a social system which is a dynamic part of society as a whole, rather than as a series of administrative agencies with independent existence, became apparent. This led to recognition of the profession of social work as a social system also. The job of examining relationships between the correctional field and the social work profession was seen in this perspective to be one of analyzing the ways in which these two social systems are currently related. The conclusion emerged that designs for modifying each system must be based on such analysis if they are to produce useful consequences.

2. The social processes which select those offenders who are to be identified and treated officially were examined, with special attention to their effect on the offender's personality, social status, and behavior.

3. Discussion of the characteristics of the correctional caseload particularly emphasized the "working class" background from which many correctional clients come and the delinquent subculture to which a number belong.[1] This led to a beginning examination of the characteristics of the "sociopathic" personality, which appears with high frequency in the correctional caseload.

4. The authority aspects of social work practice in corrections were considered with attention to:

a. The source of authority in the legal supervisory relationship of the worker to the client.

b. The problems of social work diagnosis within the authority relationship.

c. The process of individualizing the control plan for each offender on the basis of the social work diagnosis.

d. The professional problem of participating in an agency structure where controls are supported by use of legalized force. Identification of the principles by which the social worker as a professional person accepts and participates in the use of such controls emerged as a problem requiring immediate work.

5. Several ways in which agency decision-making and communication patterns influence the behavior of both staff and client were identified. This led to recognition of the social worker's responsibility for participating within the agency toward modification of structure to facilitate service.

6. The concept of the institution as a "therapeutic community" with group life as its major treatment tool was examined, and the opinion expressed that this approach had important implications for defining the role of the social worker in the correctional institution. The concept of the therapeutic community was also applied to the correctional system as a whole and to the community structure supportive to the client on probation or parole.

7. The role of the social-work educator as consultant to correctional agencies for improving services to clients was also studied. The type of consultation involved was distinguished from consultative services which are provided within administrative structures or from a school of social work to field placements. The relationship of the

educator's consultation to the agency's administrative purposes and problems was stressed.

Seven points were identified as involving attitudes necessary for continued productive work.

1. It is necessary to be continually aware of problems in communication which create misunderstanding between professional education and practice in corrections. Factors which interfere with ability to communicate include language problems such as technical terminology and overuse of abstractions; too great involvement on each side in particular outcomes; lack of patience with the time it takes to document a problem fully.

2. Every problem must be approached as a totality with respect for each participant's stake in and perception of it and his contribution to the solution.

3. The social worker must perceive himself as only one member of the group of persons necessary to solve the problems of correctional services. Many others have contributions of equal importance to make, including persons not educated in professional disciplines. The social worker must learn to hear and to understand what the contributions of these others are and to aid in the development of solutions which will involve modification of each person's point of view, including his own.

4. At this stage of exploration, everyone must be ready not to "have the answers." Formulation of issues must be kept open-ended at this time in order to permit full analysis and time for all important contributions to be made before answers are crystallized into accepted solutions.

5. Social work in the correctional field must be ready to be inventive. New ways of working in corrections can quite possibly be developed which would be much more effective than any that have as yet been designed.

6. A readiness to expect that "something can be done" is necessary.

7. All these attitudes lead toward a broader professional identification and a more productive membership of the professional social worker in the correctional system, in the university, and in the wider community.

Evident Results of the Project

It was clear from the students' summary session that the whole group had developed enthusiasm and commitment in relation to a new area of social work practice. A readiness to make new approaches in a more open frame of mind was evident in most students. Particularly noticeable was the way sociological concepts had come alive as significant tools for analysis of social-work practice. An appreciation of the possible role of the social work teacher as a consultant to agencies in the improvement of services had emerged. In the conceptual area certain issues had been identified with acknowledgment of problems which had not previously been recognized by members of the group. Certain attitudes necessary in the approach to these problems had been generally adopted, such as readiness to accept the present unfinished state of theory in the field.

One important by-product of the project was the recognition by the correctional agencies associated with it of the value they derived from the consultative services provided by the students. Several expressed the wish that comparable consultative services from the School of Social Welfare could be continued.

For the faculty, a genuine learning experience had been achieved both through sharing conceptual material and through the educational experimentation required by the project.

Most important in relation to its purposes was the fact that the project achieved its main goal—the development of a wide-spread group of persons who had shared deeply in a common experience in the effort to relate the social-work profession and the field of corrections. While this group emerged from the experience without a fully integrated understanding of the concepts they had been considering, its members had an awareness of problems they had not previously recognized and a commitment to working with others, regionally and across the country, in their solution. From them may come important contributions in teaching materials.

Through this project a number of schools of social work may have been helped to move more realistically toward improved educational services to correctional agencies. A number of persons in correctional practice have had some preparation for future teaching assignments. It is anticipated that experimental approaches to social work in corrections will be undertaken in a number of localities by project participants who will be able to communicate them more meaningfully to others in the field because of the shared experience from which they derive.

[1] Cohen, Albert K.: Delinquent boys: the culture of the gang. Glencoe, Ill.: The Free Press, 1955.

UNESCO ON MENTAL HEALTH

UNESCO's report, "Education and Mental Health,"* is a clear distillation of the wisdom of responsible students of human development recognized by UNESCO as having something important to reveal. The bulk of contributions come from Western Europe and America.

This reviewer regards this report to be the most inclusive and mature statement on the subject to be found in a single volume. The worlds of children and youth would be transformed in a wink were responsible educators and leaders in domestic affairs to act in terms of the scientific knowledge and interpretations it presents.

In the belief that a first-hand glimpse into the book's contents can give a better picture of their scope and thought-provoking nature than any comments, I have selected the sample paragraphs to compose the remainder of this "essay" in the hopes of whetting the reader's appetite for devouring and digesting the volume as a whole:

"[Since] mental development is an uninterrupted process, it is never too early to take steps to avoid possible causes of disturbed balance if we are finally to achieve that flowering of personality and that readiness to cooperate which are the two main aims of education."

. . . .

"[Since] no family unit or small community now can give all that a child needs for his personal development we can no longer equate school education with instruction. [The child] reacts to the values implicit in his school and to some extent incorporates them into his growing personality. . . .

"What distinguishes a response which is healthy in terms of future stability from one which militates against mental health is whether it brings the child into an acceptable and satisfactory relationship with his environment, or tends to withdraw him from it. . . .

"However intellectual the process may seem, all learning has emotional correlates and leads to modification of attitudes, especially in childhood, affecting them profoundly and in ways most unexpected to the naive observer. It is indeed only at a comparatively late stage that intelligence becomes a fully effective instrument in the analysis of experience and in the choice of response. . . .

"The child's world is a continuous one of which he is the center. His learning is global and all his keenly felt experience is educative. . . . Much of his learning goes on in situations which parents and teachers do not usually regard as educative ones. . . .

"The healthy upbringing of children in a restricted living space by parents rendered uncertain of themselves by the great and small anxieties and difficulties of our time is rarely achieved by the simple light of nature or by the coldly scientific application of rules deduced from psychoanalysis or from child-development studies. It requires a deeply emotional insight into the nature and needs of children, readiness to compromise on adult requirements, and a spontaneous sympathy which cannot be built by lectures, occasional advice, and a flood of pamphlets."

. . . .

"The last 50 years have seen growth both in genuine public interest in the social tasks of the school and in parent-teacher activity as a means of promoting the general growth of children. . . . Attitudes in the teaching profession are not wholly favorable to [this]. . . . [But] in spite of the difficulties encountered and the fears expressed, most teachers and teachers' organizations recognize that . . . the home and school must be brought close together and that they should jointly exercise their complementary functions. . . .

"We are still relatively ignorant of techniques necessary to ensure that men and women from different social and educational levels will assimilate psy-

*Wall, W. D.: Education and mental health; a report based upon the work of a European conference called by Unesco at the Musée Pédagogique in Paris, November–December 1952. United Nations Educational, Scientific and Cultural Organization. For sale by International Documents Service, Columbia University Press, New York. 1955. 347 pp. $3.

chological knowledge, modify their own attitudes, prejudices, and behavior to children. But it is becoming clear that one means to this end is the discussion group which systematically explores, from both the home and school standpoints, concrete examples of child behavior. Such groups should be small—8–12 persons as a maximum—informal, and, as soon as possible, conducted in an atmosphere of complete frankness. . . ."

. . . .

"The period of adolescence presents a phase where the growing human being is . . . in a state of heightened emotional sensitivity confronted with a rapid succession of new demands. This . . . period offers great possibilities, if they are used aright, both for setting straight difficulties arising from earlier faulty development and for a constructive attempt to help young people achieve not merely emotional balance, but the fullest flowering of personality. . . .

"Unlike early infancy, however, adolescence is much more a social or even a socio-economic phenomenon than a biological one. Many characteristics of [adolescents] are . . . reflections of attitudes and expectations of parents and community. . . . In many primitive tribes the transition from child to adult status is abrupt. . . . The creation of an "advanced" civilization . . . progressively prolongs the period of dependency and sets between the world of childhood and that of adult privilege, power, and responsibility, not the bourne which a brief initiation ceremony overleaps but a no-man's land of 6 or more years. . . .

"Where the mother, father, teacher or any other adult seeks to buttress his own security by the dependence and uncritical love of the young he is apt to resist the child's need to detach himself. The consequences of such adult resistance may be disastrous: either the child . . . never becomes psychologically mature, or the severance is a painful revolt, wounding to both child and adult. . . .

"A school or home which is organized on repressive principles in which children have no rights and are subject only to a web of compulsions paves the way for that conflict of the generations which is a marked feature of some societies. . . . Where the young feel themselves to be needed and to be accepted as partners in their own education and upbringing, there is no conflict of the generations. It is difficult to overestimate the importance to young people of school societies run by themselves, of youth clubs, of the right to invite one's friends home . . . of being called into family councils . . . and of being given steadily more and more responsibility for others younger than themselves for fulfilling obligations such as payment of money and the ordering of their own leisure time."

. . . .

"Creation and self-expression are . . . not infrequently . . . the most neglected aspects of secondary education. Almost the only channel officially allowed to children in many schools is the written word—and then only as a means for regurgitating what has been taught. . . . In many ways creative work performs for the adolescent and the adult the same essential psychological function as play for the child. To deny creativity is in fact to court maladjustment."

. . . .

"The multiplication of specialist teachers easily leads to a fragmentation of knowledge, to a lack of coordination between subjects, to impersonality, and, to what is perhaps worst of all, a series of competing and uncoordinated demands on children. . . . A school system which leaves a child unaided in an impersonal world of specialists is at best not assisting healthy, social, emotional and intellectual growth; at worst is contributing to the incoherence of view which marks many young people."

. . . .

"However liberal an examination may be and however well conceived, it will continue to exert an evil influence on education and militate against mental health so long as passing or failing in the critical test is regarded as the most important fact in a child's career. If adult opinion can be brought to consider examinations as a means of further guidance, as a form of assessment rather than as a competitive hurdle . . . then their value can be retained without the destructive consequences which have inspired attacks on the system itself. . . ."

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"[a major] problem of mental health is that of utilizing effectively and really—not as a palliative or a remedy—the urge of young people to count for something in the scheme of things, to be needed to serve their community, and through this to achieve a sense of personal worth, which is the very foundation of security."

HOWARD LANE, Ph. D.
Professor of Education, School of Education, New York University

BOOK NOTES

INTEGRATING SOCIOLOGICAL AND PSYCHOANALYTIC CONCEPTS; an exploration in child psychotherapy. Otto Pollak. Russell Sage Foundation, New York. 1956. 274 pp. $4.

A 2-year demonstration of application of social-science thinking to child-guidance practice is described in this book. The demonstration was a joint project of the Russell Sage Foundation and the Board of Jewish Guardians, and was carried out at the Board's child-guidance institute with the consultation of the author, who is a sociologist.

Besides describing in great detail the diagnosis and treatment of four children by this method, the book discusses theory and practice in child guidance as reflected in casework and psychiatric literature and principles operating in the divergence of theory and practice, and makes suggestions for reorientating both.

The author also makes suggestions for further research but notes that if these are to bear fruit they will have to be taken up by the child-guidance field as a whole rather than by one agency acting alone.

PERSONALITY IN YOUNG CHILDREN. Lois Barclay Murphy and collaborators. Foreword by Lawrence K. Frank. Basic Books, New York. 1956. Vol. 1, Methods for the Study of Personality in Young Children; 424 pp.; $6. Vol. 2, Colin, a Normal Child; 267 pp. $4.

The first of these two volumes describes a set of specially designed play procedures, largely projective, and shows how they brought out spontaneous reactions in a number of normal nursery-school children. The procedures were planned so that the responses would help the psychologist to know what the child is reacting to and his ways of dealing with his experience.

The book explains the principles underlying each procedure, shows how various children reacted, and suggests possible interpretations of each child's responses. The author makes clear that the procedures are not tests to be scored in a standard way, but are planned to stimulate the psychologist's sensitivity and to give him material to observe.

The second volume reports in great detail on 3 years in the life of one nursery-school child, "Colin." It describes his responses to the play techniques explained in volume 1 and to many other procedures used in observing him. The author shows how the little boy matured in such fields as social development with adults and with children, use of language, use of materials, music and painting, and school routines.

ADOLESCENT DEVELOPMENT AND ADJUSTMENT. Lester D. Crow and Alice Crow. McGraw-Hill Book Co., New York. 1956. 553 pp. $5.50.

This book by two psychologists from the faculty of Brooklyn College explains the biological and cultural bases of adolescent behavior and describes techniques used in studying teen-agers. It notes how adolescents develop physically, mentally, emotionally, and socially; reports on motivating factors in adolescents' attitudes and behavior, on problems associated with their developing sex urges, and on delinquency and other behavior deviations; and discusses the various adjustments the adolescent needs to make—home, school, vocational, and social. An appendix lists nearly 100 recommended films on various aspects of adolescent development; another presents detailed questionnaires for parents, teachers, employers, and community leaders, planned to give adults insight into their habitual attitudes toward adolescents' problems.

PATTERNS OF MOTHERING; maternal influence during infancy. Sylvia Brody. Introduction by Réne A. Spitz. International Universities Press, New York. 1956. 466 pp. $7.50.

The analysis of mothers' behavior reported in this book was undertaken in an effort to evolve and describe a systematic method for a clinical classification of such behavior.

The author and two other psychologists observed each of 32 mothers who brought their babies to a research center. The session lasted 4 hours, during which the babies—4 to 28 weeks old—ate, slept, and played, and were cared for by their mothers. Later the observations were compared with those made in a visit to each home, where a motion picture of mother and baby was made and a simple questionnaire was filled out by the mother, telling what various terms connected with babies meant to her. Each infant had been given medical and psychological tests, and each mother had been interviewed in detail about her experiences with her child.

After comparing the written observations, the author rated each mother on her sensitivity to the baby's needs, her consistency in dealing with him, and the frequency of her actions (high in tense mothers, low in withdrawn mothers). According to these criteria, she then classified the mothers in four groups.

The book presents in great detail the observations, the reasons for the ratings and classification, and the statistical processes involved. It also includes accounts of the literature on maternal and infant behavior.

SOCIAL SECURITY AND PUBLIC POLICY. Eveline M. Burns. Economic Handbook Series, edited by Seymour E. Harris. McGraw-Hill Book Co., New York. 1956. 291 pp. $5.50.

In this book the author, who is professor of social work at the New York School of Social Work, Columbia University, equips the reader for analyzing various social-security programs and policies and comparing their characteristics. Avoiding program-by-program study of social-security institutions, she discusses questions that need to be answered by a community wishing to establish a plan for economic security.

Part 1 of the book considers the nature and amount of social-security benefits and conditions of eligibility for receiving them; part 2, the decisions involved in choosing the types of risks against which some public provision will be made, such as unemployment and old age; part 3, financing of programs; and part 4, administrative issues.

IN THE JOURNALS

Accidental Poisoning

Analyzing 451 cases of accidental poisoning by chemicals other than lead and illuminating gas, Harold Jacobziner, M. D., in the *Journal of the American Medical Association* for September 29, 1956, urges physicians to persuade parents to take precautions against poisoning. ("Accidental Chemical Poisonings in Children.")

The author, who is New York City's Assistant Commissioner of Health in charge of Maternal and Child Health Services, notes that nearly 81 percent of the 454 poisonings, including 1 death, occurred in children 1 to 4 years old, an age when children like to explore the household and have not yet learned caution.

Aspirin, barbiturates and other drugs were responsible for 47 percent of the poisonings, and household preparations for most of the rest, the study showed.

In 40 percent of the cases the injurious chemical was available in an open place, such as floor, sink, table, dresser, open shelf, or drawer; in 16 percent the child managed to get at it although it was in a closed place. Removal of a substance from its original container to a household container led to many serious poisonings.

Eighty cases of lead poisoning, including 13 deaths, were analyzed separately; 87 percent of these occurred in children 1 through 3 years of age.

Breaking the News

When a physician is faced with the necessity for telling parents that their child is mentally retarded, he needs not only firm knowledge, but also human understanding, nonsentimental sympathy for the parents, concern for the child, insight, acceptance, and the well-chosen word and phrase, according to Harry Bakwin, M. D., in the *Journal of Pediatrics* for October 1956. ("Informing the Parents of the Mentally Retarded Child.")

Advising the doctor to speak frankly, yet kindly, avoiding such offensive words as "idiot" and "moron"; and to discuss the child's condition in a way that will allay any feelings of guilt and rejection on the part of the parents, the author suggests that a few complimentary words about the child will help to lighten the blow. He identifies topics that the parents want discussed as: etiology of the condition; its relation to heredity; the prospects regarding subsequent children; and the prognosis for the child's future development. The doctor may recommend institutional care, but should never insist upon it, says the author. He advises physicians to give parents an assurance of their continued interest.

Economy in Food

Food losses due to plate waste and other causes were found over a 2-year period to be much lower in two units of a cottage-type institution for children than in a large congregate institution, according to a report published in the *Journal of the American Dietetic Association* for September 1956. ("Food Expenditures in Four Institutions," by Faith Clark and Edith B. Tate.)

The study, made for the U. S. Department of Agriculture, also included two institutions for the aged.

In the cottage units only 5 and 6 percent of the money value of the food available was lost; in the congregate institution the loss was 19 percent. The authors suggest that the smallness of the loss in the cottages was due to the fact that the food was served family style, under the supervision of the cottage housemother and the cook, both of whom "paid strict attention to the 'cleaning-up' of plates." Furthermore, the report says, "The cook was also diligent about using leftovers and losing as little edible food as possible."

Successful Desegregation

Desegregation of the races in public schools is essentially a community-relations job, says Robert L. Gray, of Silver Spring, Md., in the *School Board Journal* for October 1956. ("Successful School Desegregation.") The author brings together reports of several successful experiences that were presented at a recent national conference of the American Public Relations Association, held at Washington. Three experts contributed: the consultant to an interracial group which has set up councils in 12 southern States; the director of school services of the University of Kentucky, who has recently completed a desegregation study for the Peabody Foundation; and the superintendent of public instruction in the Baltimore public schools.

As a result of their reports the author makes these suggestions: encourage individuals and groups to send in their views on how they would accomplish the mechanics of desegregation; announce a complete plan rather than piecemeal decisions which might encourage opposition and increase tension; take the job in stride not acting as though it involved an ordeal for the teachers; invite in white and Negro citizens group representatives and other interested persons to talk with the advisory committee rather than to mass meetings; assume that one does not debate decisions of the Supreme Court; open school doors to all children, but neither push nor pull a child through them.

Preparation for Childbirth

In an effort to counteract widespread misunderstanding of the techniques and purposes of a Preparation for Childbirth Program C. Lee Buxton, professor of obstetrics and gynecology, Yale University School of Medicine, describes the practices of a program of this type at the Yale-New Haven Medical Center, in the *New York State Journal of Medicine* for September 1, 1956. ("An Evaluation of a Prepared Childbirth Program.") With the purpose of lessening the fears and tensions which help to make childbirth excessively painful, the program is geared toward giving expectant mothers, through classes and individual instruction, greater understanding of the processes of birth and techniques of conscious relaxation, appropriate breathing and posture.

While one aim of the Yale-New Haven program is to lessen the use of anesthesia in childbirth the author says that analgesia or anesthesia is administered whenever the woman desires it and in many instances is urged upon her as an aid to her efforts at relaxation. He also points out that operative assistance is given whenever it is in the best interests of the mother and the infant.

PROJECTS AND PROGRESS

The Mentally Retarded

By the end of December 1956 ten States, Hawaii, and the District of Columbia had received Federal grants from the $1,000,000 of the Children's Bureau appropriation earmarked by the 84th Congress for programs for mentally retarded children. In addition plans were underway in as many other States for special projects which may also be eligible for such grants. The programs receiving grants are of three types: diagnostic and follow-up services; training projects; and a special study.

The programs with major emphasis on direct service are underway, or getting underway, in Arizona, Arkansas, District of Columbia, Idaho, Indiana, Nevada, Rhode Island, Tennessee, and Washington. All of these are stressing services to infants and preschool children including case-finding, diagnosis evaluation of potentialities, parent counseling and help to the parent in training the child at home, usually through public-health nurses. Some are demonstration projects focused on one local area, while others plan to provide service on a statewide basis.

The program in Tennessee will offer diagnostic and evaluation services not only to children of the western part of that State but also from Southern Missouri, Eastern Arkansas and Northern Mississippi. Its follow-up services will, however, be concentrated on children living in Memphis and Shelby County and will include parent counseling to individuals and groups, speech therapy, the use of hospital facilities and other community resources.

In Idaho the program will focus on a rural area and, with the use of a clinical team for diagnosis and evaluation, will attempt to find ways of providing services to mentally retarded children in rural communities without sending them away from home.

The Federally-aided programs with major emphasis on training professional personnel for work with the mentally retarded are in Michigan and Hawaii. The University of Michigan will operate a demonstration service center through which it will provide training to graduate medical students, hospital internes and residents in training and other physicians in post-graduate study as well as to public health doctors, social workers and psychologists. Service centers in Nevada and Indiana will also provide opportunities for training professional personnel. In Hawaii projects in organized group activities will be conducted by a professional team and provide professional trainees with opportunities for observation and work with children.

Child Welfare

The Bureau of Old Age and Survivors Insurance has established a Welfare Branch in its Division of Claims Policy with two major responsibilities: 1) development of policies governing the selection of the person to receive the benefit check for child beneficiaries and adults incapable of handling their own funds, the use which may be made of these benefits, and appraisal of the effectiveness of such policies in terms of the beneficiary's welfare; and 2) definition and clarification of the responsibility of the OASI program for the referral of persons from local district offices for services provided by other agencies, and for participation of OASI staff in planning activities with other agencies and citizen groups, on both a local and national basis, to assure the availability of health, welfare and other services.

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The necessity of respecting the legal rights of the child in juvenile court practice has been underscored by a recent decision of the United States Court of Appeals for the District of Columbia circuit in the case of Shioutakon vs. the District of Columbia on appeal from the District's Municipal Court of Appeals. Reversing the latter's decision, the higher court upheld the child's right to be advised that he might be assisted by counsel and to have counsel named in his behalf, as rights accrued under the District's juvenile court statute. Said the report: "Although the Act in terms neither recognizes nor withholds such assistance, the legislative history reflects congressional understanding that alleged delinquents would be represented by counsel."

In its decision the court referred several times to the Children's Bureau publication No. 346, *Standards for Specialized Courts Dealing With Children*, as well as to the report of a survey of the Juvenile Court of the District of Columbia, which was made jointly by the Children's Bureau the United Community Services of the District of Columbia, and the Department of Justice.

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In a National Family Service Appeal the Family Service Association of America is seeking $306,750 to finance both extension of its on-going services of the Association and a series of special projects. The latter would include: studies of services to children in their own homes, designed to outline methods for preventing family disruption and the unnecessary placement of children: the contribution of the family service agency toward meeting the needs of older people; the steps necessary to improve educational procedures and develop new teaching materials in social work education; guide lines for developing sound working relationships between family agencies and mental health clinics.

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In spite of a greatly increased child population in New York State between 1940 and 1954, the number of children in foster care decreased by more than a fifth, the State Board of Public Welfare announced recently. In 1950 the number in foster care—both in foster families and in institutions—was 49,660; in 1954 it was only 40,773. Among the causes of the reduction the Board points to are improved economic conditions and the success of public-health and medical services in lowering the death rate among parents of young children.

Maternity Care

As a step toward better care for mothers and their newborn infants, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, and the Children's Bureau are undertaking a study of the uses of

statistical information on hospital maternity and newborn-infant services. The Josiah Macy, Jr., Foundation is providing funds for the study.

The project aims to stimulate and help hospitals to produce and use effectively statistics on methods of care, on mortality and morbidity in mother, fetus, and infant, and, where possible, on associated pathological findings; and to promote better comparability of data obtained in different hospitals.

To these ends, the project will develop and demonstrate in hospitals of a cooperating community a workable method by which they can produce useful statistical information about their own experience and that of the community as a whole. It will provide experience of the values of such information to the hospital staffs and to local medical groups in maintaining a high level of maternity and neonatal care.

As a result of the demonstration the project expects to make available a tested method of obtaining statistical information—a method that other hospitals and communities can use for assessment of their maternity and newborn-infant services, for teaching purposes, and as a source of leads for specific research studies.

For Amputees

Several improvements in prosthetic appliances for infants and young children who are minus a hand or an arm have been worked out at the child research amputee project of the University of California in Los Angeles, according to the first report issued by the project since its formal establishment in July 1955. In the ensuing 4 months 64 children were enrolled.

Carried on jointly by the university's department of engineering and its medical school, and supported by funds from the State department of health, the project grew out of a previous clinic for child amputees at the medical school and training courses for professional personnel held under auspices of the department of engineering. Its purpose is to determine what kinds of prosthetic appliances are best suited to children, how early in life infants and young children can be successfully fitted with such appliances, and what kind of training will enable children to make the best use of them.

Through devices designed and fabricated on the basis of individual case conferences at UCLA and the incorporation of developments from experience at the Michigan Amputee Center and research at the Army's Prosthetic Research Laboratory at Walter Reed Hospital, the project has built up an upper-extremity prosthetic armamentarium. Among its additions are a special passive hand for infants and a wrist unit for very young children.

Two new and six current patients are seen each week by the case conference, which consists of pediatrician, orthopedist, engineer, psychologist, social worker, occupational therapist, prosthetist, project administrator, and secretary. The conference's prescription for fitting and training is carried out by the engineering department, which instructs both child and mother in its use. Each child returns to the project every 3 to 6 months for examination and refitting when necessary. Emphasis throughout is placed on helping both child and mother to accept the appliance emotionally.

Rehabilitation

Nineteen agencies for rehabilitating the handicapped contributed information on their programs, along with suggestions for fulfilling unmet needs, as part of a study recently made by Fordham University's School of Social Service to determine how it could better prepare students for rehabilitation work. The study was made with a grant from the Office of Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare.

The agencies, public and voluntary, all in New York City's metropolitan area, included two vocational-guidance services, two training facilities, a project for the homebound, two programs for the industrially injured, four services for special diagnostic groups, and two for recipients of public welfare funds. The study staff interviewed social workers, physicians, physical therapists, psychologists, vocational counselors, and administrators.

After studying the data collected, and agreeing with the agencies that it was not necessary at this time to develop a new social-work specialty, rehabilitation social work, the faculty recommended that the school put more emphasis on rehabilitation techniques and teach students to apply all social-work concepts to rehabilitation.

The specific recommendations urged that the school teach students about crippling diseases, occupations possible for the handicapped, the employer's problems in placement, rehabilitation agencies, and legislation relating to rehabilitation. They asked that courses in basic casework explain the meaning of illness and handicap to the afflicted person and his family. In addition they urged the school to take responsibility for selecting suitable students for work in rehabilitation and diverting others away from it; and for fostering interest, developing techniques, and strengthening personal qualities that lead to good rehabilitation work.

Training Programs

Seventy-four specialists in maternal and child health or child and youth welfare, from 31 countries, attended professional schools or observed health or welfare programs in the United States during the year ended June 30, 1956, under plans arranged by the Children's Bureau. The planned programs covered periods ranging from 2 months to more than a year.

Of these 74 trainees and observers, 29 came from countries in the Western Hemisphere; 23 from the Far East; 10 from the Near East; 8 from Africa; and 4 from Europe. The largest number—48—were sponsored by the International Cooperation Administration of the Department of State; 17, by the World Health Organization; 8, by the United Nations; one came on her own.

The group included 39 physicians; 12 nurses; 3 medical social workers; 1 dentist; 1 physical therapist; 9 general child-welfare workers; 5 social group-workers; and 4 juvenile-delinquency workers.

In addition the Children's Bureau arranged interviews or brief observation visits at health or welfare programs for 156 persons, from 51 countries; these plans covered periods up to about 3 weeks.

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In Boston, the Mater Christi Institute, which is part of a child-care center accommodating more than 250 children in 10 cottages, is cooperating with Boston College in offering a 2-year training program in child care, including classroom instruction and practical experience. Included in the center's facilities is a child-study clinic and an elementary school, while a general hospital is available for study of the needs of sick children. The students are prepared for work in clinics,

day-care centers, day nurseries, child-care institutions, and pediatric wards of hospitals through courses in child development, psychology, sociology, nutrition, home nursing, play materials, and creative art.

A statewide program to extend opportunities to nurses for continued professional education, to be sponsored by the Maryland League for Nursing, was recently recommended by a special committee of the League. The recommendation grew out of a study made by the committee showing that most of the hospital and public-health nurses in the State are insufficiently qualified even when judged by standards that the committee calls "definitely below the desirable level."

The suggested program would be guided by a new, continuing committee to be set up by the League, representing the League itself and the State nurses' association, the nursing committee of the State planning commission, the State health department, and the educational field.

Under the plan, educational centers would be established in various parts of the State, offering credit and noncredit courses, intended to meet the special needs of different groups. The centers would be located, if possible, near colleges or universities that offer courses useful to nurses. The committee suggests a plan for several 8-week sessions a year, with instruction given on the average of 1 day a week.

Since student fees will not cover the cost of some courses needed to improve nursing care or to prepare nurses for supervisory, administrative, or teaching positions, the committee recommends that the League ask the State planning commission to seek State funds to support the program for 3 years.

School Attendance

The Illinois Commission on Children is analyzing the results of a 7-month study of out-of-school children of compulsory school-attendance age. The objectives of the study are: to find out how many children in Illinois 7–16 years old were not receiving educational services in the school year 1955–56; to find ways to provide needed services for those children; to see whether the findings show need for statewide child-accounting procedures, including a school census; and to gain insight that may help in dealing with children who are poorly adjusted but are attending school. The study is being made with the support of the Woods Charitable Fund and the Elizabeth McCormick Memorial Fund, each of which contributed $6,000. An exploratory study covering schools in six counties, made in 1955, showed "a surprising number" of children 7–16 years of age out of school.

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The Bureau of Labor Standards, U. S. Department of Labor, reports that a million boys and girls 16 and 17 years of age are not enrolled in school, almost a fourth of the young people in that age group, and that half of these school "dropouts" are not employed. According to the Bureau, studies show that a greater percentage of rural than of urban youth drop out of school, that a comparatively small number drop out because of real financial necessity, and that more than half of those who leave school have normal intelligence or higher.

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The 1956–57 school year is the 12th consecutive year of increase in total school and college enrollment, according to the Office of Education, U. S. Department of Health, Education, and Welfare. The Office estimates that the 1956–57 enrollment, 41,553,000, is 1,754,300 higher than the previous peak of 39,798,700, recorded in 1955–56. Private and public-school enrollment in kindergartens and the eight elementary grades total 29,618,000, according to the estimates—an increase of 1,103,800 over last year's figure.

Research

The Children's Bureau Clearinghouse for Research in Child Life recently broadened the scope of its reporting to include research on social and health services for children. At the same time it curtailed its reporting on medical research. The only medical studies now included are those of general interest, such as studies of child growth and development, of psychological, emotional, or environmental factors affecting child health, and of health services. Masters' theses are now included in the publications only when they represent work beyond a doctorate (as in dentistry).

The Clearinghouse report, "Research Relating to Children" formerly published at irregular intervals will now be published twice a year and will be on sale through the Superintendent of Documents, Government Printing Office, Washington 25, D. C. In addition to reports of research projects, each issue will list major ongoing research programs.

Research workers who wish to register studies or ask for information should write to the Clearinghouse for Research in Child Life, Children's Bureau, Social Security Administration, U. S. Department of Health, Education, and Welfare, Washington 25, D. C.

Child Health

Georgia's State Department of Public Health recently completed a television series on an Atlanta station of 11 once-a-week half-hour programs designed to help parents promote their children's physical and emotional health. Part of a 5-day-a-week series presented by the State Department of Education and publicized by the State Congress of Parents and Teachers, the programs were planned around the theme, "Preparing the Preschool Child for School." They involved the continuous participation of a real family, containing mother, father and four children, and of a pediatric consultant physician.

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The National Foundation for Infantile Paralysis is calling on teachers to encourage school children of all ages to be vaccinated against poliomyelitis. The Foundation urges that high-school boys and girls especially be stimulated to take advantage of the present opportunities for vaccination, noting that although the disease occurs less frequently in this age group than in younger children, it often strikes the teen-ager more severely.

President Eisenhower recently urged that children and young adults who have had no Salk vaccine be given their first injection in time to receive the full three doses before next summer's peak of polio incidence and that those who have received only one or two doses be given the third one soon.

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In accordance with a recommendation by the World Health Organization that governments strive to eradicate malaria as soon as possible, to avoid the possible danger of mosquitoes' developing resistance to insecticides, the Pan American Sanitary Bureau, regional office of WHO, is giving top priority to a program to eliminate this disease

throughout the Americas. This was announced at the 1956 annual meeting of the Bureau's Directing Council, held recently at Antigua, Guatemala. It was also announced that the United States is making a special contribution of $1,500,000 for the 1957 malaria campaign.

At the same meeting the representative of Mexico announced that his Government is providing at least $16,000,000 for the 5-year malaria-eradication campaign in that country, where the disease is third among the principal causes of death. More than two-thirds of the cases of malaria in the Western Hemisphere are in Mexico, it was reported.

Mental Health

The New York State Department of Mental Hygiene recently approved a contract with the Community Council of Greater New York, providing $8,550 for a study of consultant and educational services in the mental-health field in New York City. Services provided by both public and private health and welfare agencies will be studied by the Council in collaboration with the New York City Community Mental Health Board.

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The Public Health Service, U. S. Department of Health, Education, and Welfare, recently established a new unit to help in developing research programs on tranquilizing and other drugs used in treating mental illness.

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In New York State the legislature recently created an interdepartmental board for health and mental health problems. Among other functions, the board is authorized to undertake studies of residential treatment centers for emotionally disturbed children, to contribute funds for the support of such centers on a pilot basis, and to employ a professional research team to evaluate the work.

Homemaker Services

Homemaker service is provided by 128 social and health agencies in 89 cities in 31 States, the District of Columbia, and Puerto Rico, according to information received at the Children's Bureau. Of these, 103 are voluntary agencies; the other 29 are under public auspices.

Of the 103 voluntary agencies, 47 are family service agencies; 37 are combined family and children's agencies; 4

(*Continued on page 40*)

Guides and Reports

A STUDY OF ADOPTION PRACTICE. Michael Schapiro. Vol. 1. Adoption Agencies and the Children They Serve. 152 pp. $2.25. Vol. 2. Selected Scientific Papers at the National Conference on Adoption, January 1955. Child Welfare League of America. 174 pp. $2.25. Combined purchase, $4.

The report of a project of the Child Welfare League of America to analyze current adoption practices; and papers from the conference called together as part of that project.

A GUIDE FOR THE STUDY OF EXCEPTIONAL CHILDREN. Willard Abraham. Porter Sargent, Boston. 1956. 276 pp. $3.50.

Offers concrete suggestions to groups studying various types of exceptional children; bilingual children; the emotionally and socially maladjusted; the gifted; children with physical handicaps (orthopedic, speech, visual); and the mentally retarded.

DIRECTORY FOR EXCEPTIONAL CHILDREN; schools, services, other facilities. Edited by E. Nelson Hayes. Porter Sargent, Boston. Second edition. 256 pp. Cloth $4; paper $3.

An annotated list of public and private schools and other facilities for children with various types of handicaps—mental retardation, emotional disturbance, cerebral palsy, blindness, deafness. National associations and foundations directly or indirectly concerned with the welfare of exceptional children are also listed.

INDIVIDUAL DIFFERENCES IN ELEMENTARY AND SECONDARY SCHOOL CHILDREN; the proceedings of a workshop on individual differences in elementary and secondary school children. Edited by the Rev. William F. Jenks, C. S. R., Catholic University of America Press, Washington 17, D. C. 1956. 224 pp. $2.75.

Among the subjects discussed are: residential treatment centers for the emotionally disturbed; results of therapy given to brain-damaged children; child-guidance services; education of the mentally retarded; psychological diagnosis; speech correction; remedial reading; and control of juvenile delinquency.

REHABILITATION TRENDS; mid-century to 1956. Institute for the Crippled and Disabled. 44 First Avenue, New York 10, N. Y. 1956. 96 pp. $2 plus postage. Discounts on quantity purchase.

A guide for establishment of comprehensive nonprofit rehabilitation centers.

RESIDENCE LAWS: ROAD BLOCK TO HUMAN WELFARE; a symposium. National Travelers Aid Association, 425 Fourth Avenue, New York 16, N. Y. 1956. 31 pp. 50 cents. 20 percent discount on orders of 100.

Seven papers presenting evidence that children and adults are deprived of essential services by State laws requiring specific terms of residence for eligibility for public services.

LOUISIANA AND CHILD LABOR. Compiled by Kathryne E. Mullinnix. School of Social Welfare, Louisiana State University. Louisiana Youth Commission, Baton Rouge. March 1956. 138 pp. Free from the Commission.

Analyzes the provisions of the present Louisiana child-labor law, enacted in 1942, and evaluates its effects on the welfare, education, and employment of children and youth.

UNITED STATES GOVERNMENT PUBLICATIONS IN SOCIAL WELFARE; a selected bibliography. Second edition. Compiled by Winberta M. Yao. Council on Social Work Education, 345 East 46th Street, New York 17, N. Y. 1956. 80 pp. $2.

Planned to serve as a basic, permanent guide for locating and acquiring U. S. Government publications in social welfare, this edition will henceforth be kept current by annual supplements.

STANDARDS AND GOALS FOR METHODIST CHILDREN'S AGENCIES. Board of Hospitals and Homes of the Methodist Church, 740 Rush Street, Chicago 11, Ill. 1956. 55 pp. $1.

Discusses the organization and administration of children's agencies in relation to personnel, social and health services, plant, grounds, and equipment.

"FORWARD-LOOKING . . . SELFLESS SERVICE . . . FOR 30 YEARS" *President Eisenhower*

"My dear Mr. President," Martha M. Eliot, M. D., wrote on October 31, 1956, to President Dwight D. Eisenhower, "I respectfully request that you accept my resignation as Chief of the Children's Bureau, to be effective January 1, 1957. I am asking to be relieved of my duties on that date to accept appointment by Harvard University to its School of Public Health as Professor of Maternal and Child Health.

"It is with regret that I bring to a close my long official association with the Children's Bureau. To one who believes so thoroughly, as I do, in its purposes, there can be no termination point in my unofficial support of its work.

"For more than 30 years I have had the great privilege of serving our Government. This has given me a rare opportunity to unite my efforts with those of many others, inside and outside this Bureau, in multiplying the ways through which successive generations of children throughout our Nation may become fit, physically, mentally, and socially, to take their place in our increasingly complex society. It has been my good fortune, also, to work for the better health and well-being of children in many lands through agencies of the League of Nations and of the United Nations. I know of no task more satisfying than public service.

"Tremendous progress has been made in these 3 decades in saving life, in preventing and reducing serious economic, social, and physical handicaps in childhood, and in extending and improving health and welfare services for children through Federal, State, and local action. These are accomplishments of the Nation in which the Children's Bureau has played a part, but only a part. Very great credit must indeed go to many other public agencies and to many civic and professional groups that through the years have made, and continue to make, the well-being of children their major concern.

"Those of us who are engaged in work for children are keenly aware, however, that much remains to be done. Far too many children now fail to benefit from the advances that medicine, education, and the biological and social sciences are constantly making. But we are no longer content just to ward off or treat the physical, mental, and social ills of childhood. Our goal is the optimum development of every child. If this is to be attained, the needs of children must receive much higher priority in our public and personal budgeting of time, thought, and money, than they now receive. In my opinion there is no more important matter before us today.

Dr. Martha M. Eliot

"To make progress in achieving these goals we will need the combined and continued efforts of the Federal, State, and local governments and of many voluntary groups and organizations. We will also need a constant flow of new knowledge from scientific sources as to what makes for healthy and happy childhood. New emphasis on research in child life is especially urgent just now as the impact of developments in the physical sciences, automation, and urbanization is increasingly felt.

"The Department of Health, Education, and Welfare embraces not only the Children's Bureau but many other units whose work affects the lives of children in fundamental ways. This Department is in a strategic position to give national leadership, both within the Federal Government and in cooperation with the States and voluntary groups, in ushering in a new era of health and happiness for children everywhere. . . ."

The President's response

"It is with sincere regret," President Eisenhower wrote Dr. Eliot on November 8, "that I accept your resignation. . . . In leaving your post, I trust you take with you the deep satisfactions that you have so rightfully earned for the splendid leadership you have given over the years to the cause of better health and welfare for children, not only in our own Nation but around the world. Your contributions to this cause have been invaluable. Future generations of children will be the beneficiaries, as past generations have been, of the forward-looking and selfless service you have given in their behalf for 30 years.

"I share with Secretary Folsom the hope that your new activities will be richly rewarding and that we may count upon your advice and help in the years to come."

Marion B. Folsom, Secretary of Health, Education, and Welfare also wrote to Dr. Eliot saying:

"Your decision to relinquish your position as Chief of the Children's Bureau is a matter of deep personal regret to me and, I know, to many others throughout the Department. . . .

"In your 30 years' association with the Children's Bureau, you have unfailingly brought the highest standards to your work. You have shown imagination, energy, courage, and great ability. . . . Your influence in helping to give children a safe, healthy, well-adjusted start in life has been felt not only in this country but around the world. In this way, you have been helping to build foundations for a better, more peaceful world in the future. . . ."

READERS' EXCHANGE

DOMKE AND BUCHMUELLER: *Issues of policy*

The St. Louis County project described by A. D. Domke and Herbert R. Buchmueller is exceedingly important both as a demonstration and as an experiment. ("Preventive Mental Health Services in Public Health," CHILDREN, November–December 1956.) It is to be hoped that more communities will undertake such activities. As new approaches to the mental health problems of school children are developed it will be important to identify not only problems of technique and procedure but also the basic issues of policy that are involved.

One such issue has to do with the operating relationship between public health and public education. As the agencies in these fields begin to work more closely together it will be necessary for us to establish better communication at the same time that we identify reasonable boundaries. Our primary need is not to draw hard and fast administrative lines so much as it is to clarify our purposes, functions, and available competence. Workers in public health and public education should share the strongest possible mutual respect for the responsibilities of each area. Emphasis must be placed upon maximum cooperation in the public interest and the elimination of competition and duplication.

Another issue to be faced has to do with fees for service. In the early stages of public education lines were frequently drawn between the children whose parents could pay for their education and those whose parents could not. In many places the first public schools were pauper schools. As we came to apply in public education the principle of equal opportunity regardless of economic status, we put behind us the divisive effect of the means test. What, now, are the implications of this experience and this principle for mental health services for public school children? Can we justify, in public health programs for children, economic discriminations which we long ago rejected in public education?

John H. Fischer
Superintendent, Baltimore Public Schools, Baltimore, Md.

OVERTON: *Detached appraisal*

I have read with interest Alice Overton's article, "Casework as a Partnership." (CHILDREN, September-October 1956.) The project it describes is important as an indication of awareness on the part of professional persons that new ways must be found to approach the problem of rehabilitation of families whose behavior is damaging to children and who have been unable to make use of the usual social agency service.

The keynote of the effort described in Miss Overton's article is "partnership" with the families, an endeavor "to develop in them a sense of full collaboration." This certainly is an essential in any therapeutic attempt, but how to bring it about when one of the proposed partners is weak, sick, disillusioned, unwilling, is a real challenge. In a therapeutic partnership it is essential that one partner be stronger and more secure. Miss Overton describes the initial confusion on the part of the workers in attempting to use an approach other than the traditional, fearing "to intrude on people who have not asked our help" and the resultant specious attitudes on the part of the workers and of the families. The workers, however, appear to have made progress in achieving greater security and realism in approach.

Another source of strength which may be brought by the worker is her scientific knowledge. Miss Overton suggests that progress may have been due not to casework skill but "the sense of complete investment made by the workers and caught by the families." Such investment on the part of workers is essential and basic, but it must be accompanied by detached appraisal of motivation and capacities in order to make a true contribution to the field in general.

This group deserves recognition for its open-minded and experimental attitude toward a problem which is of serious and widespread significance.

Marjorie Harb
Chief Psychiatric Social Worker, University Medical Center, Rochester, N. Y.

HOWARD: *Training schools, too*

In his letter regarding my article, "If Institutional Treatment is to Succeed," (CHILDREN, September-October 1956) Abraham Novick points out that there is a difference between the care of delinquent children and those who leave their own homes because of problems which do not bring them into court. ("Readers' Exchange", CHILDREN, November–December 1956.) Preparation of a child for entering a training school from a court certainly presents problems, but not the least of these is likely to be the seriously traumatic effect of separation from his family on a child who is already emotionally upset over his own behavior, arrest and court appearance.

It seems to me, and I have seen it demonstrated, that proper handling by the court, the probation officer, and the detention home can do much to help such children prepare themselves for separation. But even with the best of preparation the child will need continued help from the institution to learn to live with the fact of separation.

I would suspect that many children entering training schools have not had any help with this problem prior to admission. Wouldn't they be better able to take advantage of what the school has to offer by approaching it with a more constructive attitude if someone had helped them to work out some of their feelings and to discharge their hostilities?

Space does not permit a full discussion of Mr. Novick's objection to the idea of group pressures and proper grouping of children. Of course, any good social worker reads a case history to find the basic problems facing the child as well as his symptoms. Nevertheless, symptoms still are important. If a school has a group of children all of whom are involved in gang stealing, this is going to set a climate regardless of the many and varied reasons why each child in the group indulges in this behavior. Therefore, despite our concern about individual reasons back of

this behavior, we find ourselves working with the symptom.

One of the values of a system of many small institutions, such as the Borstal System, in place of one large institution, is the possibilities it offers for grouping. Because I feel that this problem of symptom contagion is a real one, it seems to me that it is one that training schools need to consider seriously. Since such schools cannot usually control their intake, they must use internal grouping to bring about a more constructive climate.

Frank M. Howard
Executive Director, Albany Home for Children, Albany, N. Y.

BOOLE: *A questioning role*

Lucile G. Boole's article "The Hospital and Unmarried Mothers" (CHILDREN, November-December 1956) is most timely in calling attention to the role of the hospital staff in working with unmarried mothers.

Miss Boole's emphasis on the importance of recognizing the interrelationship of medical, social and emotional factors is well taken. The understanding approach of the entire hospital staff which she describes is one which other staffs could study with profit.

However, I would raise one question in regard to the role of the medical social worker, as described in the article. It is my impression that the field of social work has a unique role in working with the unmarried mother—the evaluation of the individual as a potential parent. Miss Boole states that "the right of the patient to formulate and execute her own plans is acknowledged." While I agree with this philosophy, I would like to suggest that among this group of patients, one frequently finds girls who are suffering from severe personality disturbances. Doesn't the medical social worker have a responsibility for raising questions as to the adequacy of individual mothers for giving the child the love and affection needed to insure good emotional development or for making mature decisions that will be in the best interest of both her own future adjustment, and that of the child?

Such questions, of course, involve a discussion of casework practice, but it seems to me that they are pertinent to a consideration of the functions and relationships within the hospital staff. They impose also, a need for clarification of social work function with the agencies in the community which may be working with the unwed mother and assuming the primary casework responsibility with her.

Genevieve B. Short
Director, Medical Social Service, Colorado General Hospital

ELIOT: *Citizen participation*

Dr. Eliot quite correctly stressed the importance of enlisting the understanding, initiative, and participation of the people in nations receiving technical and other assistance from the United Nations family of organizations. ("International Effort for Human Welfare," by Martha M. Eliot, CHILDREN, September–October 1956). Equally important to the future of these constructive international programs is the understanding and support of people in countries such as the United States where technical assistance is less urgently required. As might be expected, the types of programs described by Dr. Eliot—those seeking to improve conditions of health, nutrition, and education—have been most successful in attracting the interest of a wide cross section of our citizens.

Since the United Nations Children's Fund functions in close cooperation with the World Health Organization, the Food and Agriculture Organization and the U. N. Bureau of Social Affairs, citizen interest in UNICEF has brought about a gratifying growth of understanding of the work of all these agencies. Organizations such as the United States Committee for UNICEF and the National Citizens Committee for WHO exist to provide channels for citizen participation in U. N. programs. Their work is greatly assisted by the community of voluntary organizations—the churches, the civic and service associations, the youth groups, and many others—which have found support for the work of the United Nations family to be in accord with their convictions and objectives of service.

The future direction and success of the United Nations depends on the understanding and interest which these organizations and their counterparts in other countries are helping people achieve.

Norman Acton
Executive Director, U. S. Committee for UNICEF

PROJECTS AND PROGRESS

(Continued from page 37)

are children's agencies; 9 are health agencies. The types of 6 are not identified in the reports.

The 25 agencies that provide homemaker service under public auspices include 22 local or county departments of welfare. In addition, 3 States—Colorado, Florida, and Idaho—and 1 Territory, Puerto Rico, provide homemaker service on a case-by-case basis rather than as a formal program. Another State, Texas, provides case-by-case homemaker service but only where child welfare units exist.

Other State public welfare agencies which do not give homemaker service directly provide leadership, consultation and some financial assistance to selected county welfare departments to enable them to give the services.

South Dakota, and Hawaii have budgeted State-Federal child-welfare services funds for homemaker service.

Facts and Figures

Aid to dependent children payments went to fewer families and children in the year ended June 30, 1956 than in the preceding year; but the amount paid monthly per family increased, according to the Bureau of Public Assistance, Department of Health, Education, and Welfare. In June 1956 payments went to 613,700 families, 6,600 fewer than in June 1955; the families included 1,707,600 children, 15,867 fewer than in June 1955. The average amount paid per family rose from $86.78 to $89.27.

. . .

The fertility rate (births per 1,000 women 15-44 years of age) in the United States rose for the fourth successive year in 1954, according to the National Office of Vital Statistics, Department of Health, Education, and Welfare. The 1954 rate, adjusted for under-registration of births, was 117.6 This was 2.5 percent above the 1953 figure. The rates for 1952, 1951, and 1950 were 113.5, 111.3, and 106.2.

. . .

Although 99 percent of births to white women in the United States in 1954 were attended by a physician, only 81 percent of births to nonwhite mothers were so attended, according to the National Office of Vital Statistics.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

THE AMERICAN WORKERS' FACT BOOK. Department of Labor. 1956. 333 pp. $1.50.

This report is planned to give a brief overall picture of labor's place in the economic life of the United States to employers and employees, newspaper editors, labor representatives, legislators, administrators of labor affairs, and educational institutions. The sections on employment of children and young people present information on such subjects as legislation for the protection of young workers; school attendance laws; migratory agricultural laborers; working mothers; and youth in the labor force.

EDUCATION FOR NATIONAL SURVIVAL; a handbook on civil defense for schools. Department of Health, Education, and Welfare, Office of Education. 1956. 88 pp. 65 cents.

This handbook contains suggestions to assist school administrators and teachers in planning protective measures for school civil defense. It includes checklists for the administrator, for teachers, and for other school personnel; lists of films and publications; a step-by-step outline for drafting a school civil-defense plan; and a form of reporting on an exercise in school evacuation. The publication was prepared by the Office of Education under a delegation of authority by the Federal Civil Defense Administration.

TEACHING ABOUT THE UNITED NATIONS IN UNITED STATES EDUCATIONAL INSTITUTIONS, January 1, 1952 to December 31, 1955; a report by the United States of America Under ECOSOC Resolution 116 (VI). Fredrika M. Tandler. Department of Health, Education, and Welfare, Office of Education. Bulletin 1956 No. 8. 40 pp. 25 cents.

Reports from public and private schools and colleges in a number of States are presented in this pamphlet as a profile of what is being taught about the United Nations. A section is included on how adults learn about the United Nations through educational institutions, community activities, national organizations, and the mass media of communication.

WHY CHILD LABOR LAWS? Department of Labor, Bureau of Labor Standards. Bulletin No. 185. 1956. 22 pp. 15 cents.

Originally published in 1946, this bulletin brings up to date information on Federal and State child labor laws and their effect on employment opportunities; and discusses child labor standards and the uses of employment certificates.

SELECTED REFERENCES ON MIGRATORY WORKERS AND THEIR FAMILIES; problems and programs 1950-1956. Department of Labor, Bureau of Labor Standards. 1956. 16 pp. Single copies available from the Bureau without charge.

Lists more than 100 reports on migratory agricultural laborers and their families, including reports of State and local programs in their behalf.

HOMEMAKER SERVICE; a directory of agencies in the United States and Canada. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1956. 27 pp. Single copies free from the Bureau.

A listing of 128 public and private non-profit agencies, in 89 cities and 31 States, offering an organized homemaker service. No attempt at evaluation is made.

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Charles Schottland, *Commissioner* • Martha M. Eliot, M. D., *Chief*

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Pure delight—so obvious on these children's faces—comes easily in childhood when the channels for enjoyment have not been clogged by distorting experiences. Different formulae will produce it in different children, since children vary in their reactions because of both constitutional and cultural factors, as the article beginning on page 43 points out. The formula illustrated here, however—sunshine and space, a congenial playmate, a baby animal and the freedom to enjoy them—has been proved widely effective down through the ages.

◀ *the authors*

Pediatrics and psychiatry are combined in the equipment of Dr. Milton J. E. Senn for directing the child-development studies at Yale. With his medical training from the University of Wisconsin followed by special study in pediatrics at Washington University, St. Louis, he became a Commonwealth fellow in psychiatry while on the pediatrics staffs of the New York Hospital and Cornell University Medical School. He has been at Yale since 1948.

Although now busy planning for the expansion of services to emotionally disturbed children at the Infants Home of Brooklyn, Saul Hofstein drew the points in his article from his 10 years of experience with the Jewish Community Services of Long Island. With both a master's and doctor's degree in social work from the University of Pennsylvania, he is a member of the Commission on Practice of the National Association of Social Workers.

Psychologists William C. Rhodes (left) and Phyllis Matthews (right) have both changed their jobs since writing their joint report on the project to combat maternal deprivation in Cobb County, Ga. Dr. Rhodes, whose Ph. D. is from Ohio State University, is now associate professor of psychology and director of the Child Study Center at George Peabody College in Nashville, Tenn. Mrs. Matthews, who was child psychologist at the Marion Howard School in Atlanta as well as at the Cobb County Health Department, resigned from both positions when her first child was born last August.

Before joining the staff of the National Child Labor Committee, labor economist Sol Markoff was on the fact-finding staff of the Midcentury White House Conference on Children and Youth. He has also served as a consultant in the one-time Industrial Division of the Children's Bureau, as a labor economist in the U. S. Department of Labor, and as a labor arbitrator for the National War Labor Board.

William H. Sheridan (left) has been with the Children's Bureau for nearly 8 years, serving as consultant on delinquency before the establishment of the present Division of Juvenile Delinquency Service. Previously he was chief probation officer in the juvenile court in Cleveland. Edgar W. Brewer (right), once a probation officer in the juvenile court in Seattle, supervised child guidance centers for the Washington State Division of Children and Youth Services before coming to the Bureau in 1955.

A review of child-development research and child-care trends shows continuing competition between . . .

FADS AND FACTS AS THE BASES OF CHILD-CARE PRACTICES

MILTON J. E. SENN, M. D.
Chairman, Department of Pediatrics, and Director of Child Study Center, Yale University

IT IS NOT EASY to be objective in evaluating the influences of research, or to predict which investigative work will initiate a new trend. A vast amount of research work is going on, and it is difficult for any one person to be intimately familiar with all of it, even in one's own country. Each of us engaged in research in child development is so busy with his own small project that he cannot keep informed in an adequate fashion about studies elsewhere, nor can he give up the notion that his investigations are preeminently important not only for the present, but also for the future.

In examining the wider area of research in child development, I have considered as current not only studies of the past year or two, but those produced in the past 10 years. In order to get a historical perspective, I have also examined earlier efforts in child-development research carried on since the turn of the century. This paper will mention first some of the impressions I gained from the historical review.

First, I have been impressed with the fact that trends in child care often do not await scientific evidence for support. The flood of child-care methods based on behavioristic theory carried on in the 1920's and 1930's and the tide of permissiveness in the late 1940's did not develop from the appearance of large bodies of scientific data which had been arrived at by careful research. Instead, they resulted much more as parts of other forces—rebellions at practices of child care which for one reason or another were considered unsatisfactory or injurious. For example, the scheduled and impersonal practices of habit training in the 1920's were part of the impersonality of the scientific methods which flourished at that time and which were so effective in controlling disease. When as a byproduct there developed an unexpected abundance of certain kinds of behavior problems, it was natural that a reaction characterized by self-regulation should begin in the 1940's.

Practices of child care are never isolated from other important, dynamic forces in society; rather they reflect changes taking place in other areas—general economic, cultural, and psychological. Changing patterns of thought about matters which affect our society as a whole influence what we do in the care and education of children in the home, the nurseries, the school, and the church.

The fact that we rear and educate our children by methods based much more on empiricism than on scientific foundations may not be entirely bad. However, it explains the rapid shifts in our practices as well as the misinterpretation and misuse of the small amounts of data which have been gathered. I have the feeling that we could do better if our child-care practices were built on solider findings of scientific investigation. For that reason I am a strong believer in the need for greater support, financially and in every other way, of child-development research in our universities, which should be the ideal places for objective, systematic, and comprehensive evaluation of growing children.

My second discovery which has resulted from a study of the past is that trends may develop from either the scientific studies of a few people, or of a single person, or even out of the impressions of a few

Based on a paper presented at the 1956 biennial conference of the Play Schools Association.

people, if their beliefs are given wide publicity, are stated forcibly, and are presented to the general public at a time when it is ready to accept them.

Starting a Trend

For example, the "success formula" for starting a trend, or at least a fashion, in child care would be to choose a subject like adolescent behavior which is puzzling many parents and educators; then to interest a person well known for his work with children to the extent of having him state his opinions about adolescence, even if these are based only on a small sample of observations and clinical impressions. The opinions if presented in writing to an enterprising literary agent will find a ready publisher, and with skillful and abundant pre- and post-publication advertising may not only become the contents of a best seller but find even greater distribution by radio and TV. For the time being, the answer to the riddle of adolescence will seem to have been found; but only until disillusioned parents have learned that the problems of life are not so easily dealt with and until another prophet appears to lead them out of the wilderness.

It is particularly easy today to stir up parents about child-care practices since so many are taking their roles seriously and are buying books and magazines as never before in order to be well informed. As a result, every publishing company of any size has its own line of books on child development and child care. Magazines and newspapers carry articles on these subjects in almost every issue. Unfortunately the demand and the competition are so great that there is often a lack of discrimination in accepting books for publication.

Close scrutiny of books on child development for parents and professional people indicates that writer and written material are usually selected on the basis of what has a ready sale. Material which is palatable, which is considered common sense, and which will not stir up self-criticism, is favored. Since people believe what they want to believe, and read what they want to read, and see what they want to see, they are fed the products of persons who are not always scientifically objective, but who in the name of science, and on the theory that it is bad to stir up parents emotionally, give them what they think parents want instead of what they need.

Thus the public, professional and nonprofessional alike, has been much more willing to accept as causes of emotional disturbance in children such factors as constitution, body build, physical disease, and single psychological determinants than the deep unconscious mechanisms within the child, or the multiple, mass influence of social forces. We have been as naive in thinking that because a child in infancy has a certain body build he is doomed to a life of delinquency as in believing that the lack of breast feeding predisposes a child to mental disturbance. At the same time we have closed our eyes to what is known about the harmful influences of excessive competition and of general failure to accept human differences, because in our society competition is believed to have a growth-enhancing influence and difference is looked on as pathology.

Influences on Research

This brings me to another discovery in my search for a historical perspective, which is that the findings of research on child development may have a delayed influence on child care. A great part of current research is still influenced by an important body of clinical studies on adults and a few children and a vast collection of theoretical formulations on personality development made over 50 years ago. I am referring, of course, to the psychoanalytical work and theories of Freud.

It took a long time for Freud's writing to be widely read with sympathetic understanding. But today few social scientists will dispute the importance of the emphasis placed by psychoanalysis upon childhood experiences as precursors in the formation of personality. However, despite their ready acceptance of this relationship, most social scientists and psychiatrists see a need for a continuous and critical examination of the ways in which early-life experiences affect later behavior. This is the reason why much of the research in child development today is directed toward testing out and evaluating psychoanalytic theory, especially with detailed long-term studies of groups of children.

Freud was neither the first nor the last to see the advantages of long-term observation. Excellent observers, both past and contemporary, from Charles Darwin [1] to the psychologist Piaget [2] of Geneva, have recorded observations over several years on their own children. One of the marked characteristics of current research in child development is that it has a long-term, or longitudinal, element. Modern investigators are interested in observing the same children, beginning with their prenatal existence, for as many years as possible, on as many occasions as feasible, by as many different observers as practicable.

Another characteristic of current research is its multiprofessional and interprofessional nature. Psychologists, pediatricians, sociologists, anthropologists, psychiatrists, public-health personnel, and schoolteachers are joining together in such studies. But they are not only studying the child in isolation through a one-way vision screen or in an interview or through a test. To these traditional approaches, they are adding techniques which bring them data about the child living in a family, going to school, and playing with others.

While research workers continue to be interested in the influence of the child's state of health at birth on his later development, they are focusing more sharply today than ever before on the physical and biologic equipment of the newborn. They are examining individual differences of babies at birth in the light not so much of deviancy or potential pathology, as of normal variation, an important sign of individuality and of the child's potentiality for healthy development and behavior.

Although the spotlight of study centers on the individual, its range includes his ever-expanding environment. However well or poorly endowed the human individual may be at birth, either because of biologic inheritance or other constitutional factors, the moment he enters the world there begins an increasingly intensified interaction between him and many forces outside of himself. Preeminent among these are people- first his parents, his siblings, and other members of his family, and eventually others such as physicians, nurses, educators, theologians, recreation leaders, and playmates. Physical forces in the environment along with social, economic, and cultural forces also continue to influence and to modify him. The degree and direction of their influence, for harm or for good, are some of the concerns of current investigators. As more and more is known about human heredity and the chemical-physical elements of genic influence, more will be known about the prevention of physical as well as psychological pathology; but this is probably pointing more in the direction of research for the future than of today.

Child-development research is broader and more comprehensive today than heretofore. The goal of the investigator has also changed.

Since the turn of the century, child psychologists have gathered a myriad of facts about behavior which they have put into encyclopedic books for parents and professional colleagues, stringing one fact after another on a thread of chronological age. The subjects studied were usually so called "normals" whose growth was charted by birth dates. The reports were purely descriptive with only rare speculation about the whys and wherefores of the behavior noted.

Today, the meaning of behavior is the chief concern of the investigator. Behind this is the belief that the appraisal of behavior in terms of normality and pathology, as well as the prevention and treatment of behavior problems, will be more likely to be successful if based on a proper understanding of the dynamics of behavior. Perhaps, if parents and educators are helped to reason about phenomena rather than to try to match a child against a set of so-called developmental norms, they will, like the researchers, become more knowledgeable about child development and happier in their use of their knowledge.

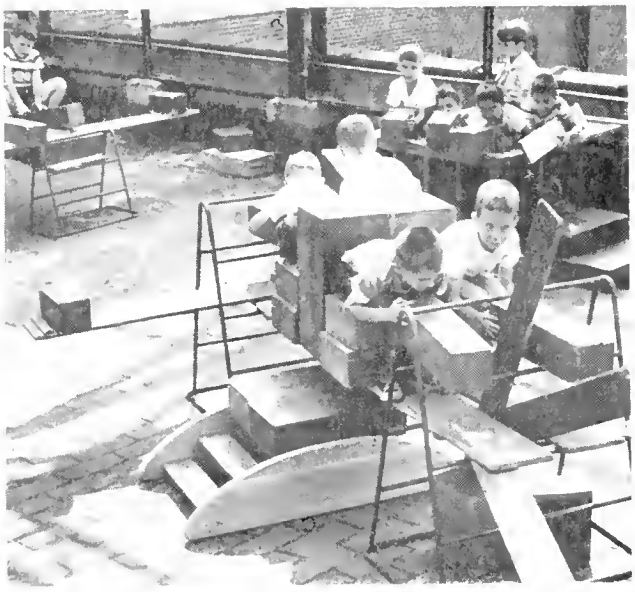
Some Findings

What are some of the findings of current research which might have practical value to parents and to professional persons working with children? I can here present only a few.

Probably the most important single finding, which has come out of many studies, is the demonstration of the variety of normal differences in human beings. "Normal" babies differ greatly from each other at birth as do "normal" children of every age.

Present-day research is re-enforcing concepts about the role of the unconscious in human behavior. It is also verifying the existence of a psychological defense system, built into each healthy person, which protects him from excessive vulnerability to the many stressful situations encountered daily. The origin of these mechanisms seems to be in early childhood and to revolve particularly around the parent-child relationships. From this it becomes evident that any efforts toward making his early relationships stable will help the child establish clear concepts of himself and of other persons. As he is supported and accepted by loving parents he will learn to share this love with others. As the child grows, participation in group life outside the family will further assist him to gain understanding of himself and others and help him cope with frustrations which confront him as an individual and as a member of a group.

Longitudinal studies, especially those of Macfarlane at the University of California, demonstrate that normal run-of-the-mill children of a white, middle-class group in our generation show many characteristics of behavior which parents consider



Children in an after-school play group in New York City ride an Air Force bomber they created out of a few blocks. Observation of normal children at play together or alone is one method used in current research projects in child development.

problems, but which in themselves are not indicative of mental pathology. The traits commonly found in these normal children were enuresis, speech difficulties, temper outbursts, nailbiting, transitory lying and stealing, fears, thumbsucking, restless sleep, physical timidity, irritability, jealousy, overdependence, food-finickiness, and sex play. In other words, all traits which may represent mental illness in adults and children appear at one time or another as normal characteristics in childhood. The diagnosis of neurotic disturbance may only be inferred if a given child has an overabundance of any of these traits at one time or if any of them are unusually prolonged, particularly if they interfere in the child's development or result in his failure to participate satisfactorily in the life of his age group.

The findings show, however, that while these traits do not represent a problem to the child or bring him any concern they do bother his parents. This has led pediatricians, teachers, and other professional workers to realize that whether or not a behavioral trait is pathological it is a problem requiring attention as long as it causes somebody to be anxious and to worry. The person who needs direct assistance or therapy is the person who is worried, usually the parent. This has led to a redefinition of the role of professional persons concerned with children, requiring them to provide psychological help to persons who are anxious. However, since the number of persons who ask for help with such problems is great, attempts at group therapy and group education have become increasingly necessary.

Other research workers have pointed out also that not only do behavioral traits come and go in the life of a child because of his nature as a changing and growing human being, but that social class and other cultural influences are often responsible for the differences in behavior among children of various groups. Child behavior which is encouraged and rewarded by one social class may be worried about, disapproved and punished by another. Therefore professional persons appraising both the normality of a trait and methods of dealing with it must take into consideration the cultural background of the child.

In line with this the researchers have found that children's preferences for leisure-time activities vary with their social background. Even if a child lives in a neighborhood or goes to a school including children from several social classes, his recreational interests are likely to attract him to peers of similar social background. One study, for example, found that half of the children from upper middle-income families in a certain city belonged to the Boy Scouts, while almost none of those from low-income families were members. "Middle-class" children went to church more, read more books, spent more time listening to the radio, and were somewhat restricted in movie attendance. "Lower-class" children, on the other hand, went to movies frequently but did relatively little reading or radio listening.

About Prediction

We have learned to be more cautious in predicting behavior. For example, longitudinal studies which began with detailed analyses of pregnant women have in the past occasionally predicted prenatally that some of the subjects would be poor risks as mothers. To the consternation of the investigators, it was subsequently demonstrated that some of the women who had seemed destined to fail in the mothering relationship turned out to be the most effective and happiest, while others who had seemed sure successes had difficulty in the day-by-day care of their children. Predictions about the behavior of the children proved equally fallacious. Some children who when small seemed unusually dependent and clinging, later when the time came for them to go to school showed little hesitancy about separation from their mothers. This does not mean that prediction is completely invalid, but that the possibility of change in a human being is so great that errors of prediction are frequent.

Other findings have to do with the relationship of physical development and general health to emotional adjustment, intelligence, and school performance. Today wide variations in rates of physical growth and in body size are accepted as normal. However, while the fact has long been known that certain types of mental deficiencies, such as cretinism, are accompanied by arrested physical growth, only recently has a relationship between physical and mental development in healthy children been demonstrated. Two studies of this subject have indicated that intellectually gifted children not only rank higher in school grades and in achievement-test scores but also tend throughout the growth period to be superior in physical development.

Such a positive relationship between physical status and intelligence may be explained in a number of ways. For example, it is possible that intelligence and development are positively correlated because they are both results of the same genetic factors. However, it is also possible that environmental factors, such as a family with adequate financial resources, provide advantages which are stimulating both physically and intellectually—such as good diet, proper medical care, interesting books and toys, and space enough for privacy.

Current research has given much attention to the problems of juvenile delinquency. While many data have been collected, some of them very controversial, one particular study stands out as revealing a way toward prevention. A group of psychologists under the direction of Roger Barker studied children and parents of a small town in the Middle West.[4] After following their human subjects closely day after day at home, at play, and at school, they reported that in this community the children were on the whole relaxed and healthy, lived at a comfortable tempo with time to explore and master their environment, and received a great deal of warm, encouraging companionship from adults. In this community delinquency was unknown.

Child-Care Practices

In our country the child came to society's serious formal attention first as an object to be protected legally and spiritually. With the rise of science, attention focused on him as an object for study, first of his physical self, then of his intelligence and learning, and then more recently of his emotional and social development. It would be hazardous to predict what influence present-day research in child development will have on child-care practices. To some extent the future is in the research workers' hands. Yet human beings are constantly being swept along by forces which have little or nothing to do with science.

At the present time evidence is mounting to indicate that child-care practices are turning away from the permissive approach toward the opposite extreme of coercion. Trends in infant feeding are turning again in the direction of regular, rigidly held schedules. And while the public is told that it must "love or perish," parents are warned against giving too much love. Schoolteachers are advised to go back to teaching the three R's, and to give up the "frill" of child guidance. Recently a county supervisor in Ventura, Calif., during a discussion of a proposal for employing a psychiatrist for the school system, suggested that "it would be a lot cheaper to buy switches for the teachers." The supervisors failed to order the switches, but neither did they take any action in regard to the psychiatrist.

It is quite likely, one at least hopes, that despite the shift away from the kind of permissiveness based on the individual needs of human beings, all the gains made in that direction in the past several years will not be lost. At least we can still find this recipe for "preserving" children in a popular cookbook:

> 1 large grassy field
> 6 children
> 3 small dogs
> A narrow strip of brook with pebbles
> Flowers
> A deep blue sky
>
> Mix the children with the dogs and empty into the field, stirring continuously. Sprinkle the field with the deep blue sky and bake it in a hot sun. When the children are well browned they may be removed. They will be found right for setting away to cool in a bathtub.

All the ingredients are not always available, but it is the philosophy that counts.

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What besides personality factors are involved in a child's ability to profit from mental-health services? A social worker discusses . . .

SOCIAL FACTORS IN ASSESSING TREATABILITY IN CHILD GUIDANCE

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SEPARATION OF SOCIAL factors from the intrapsychic dynamics involved in the selection of cases for treatment in child guidance constitutes a most difficult task. A child, whatever inner forces or conflicts give rise to his need for treatment, expresses his anxiety through his behavior within his family and in other social relationships. Whatever clinical criteria may be established for success in treatment, the community measures its effectiveness through the child's ability to function better within the community. Similarly, the child's problem, whatever its inner expression, represents, in part, an internalization of factors in his social relationships. Since the child is in an ongoing and close interaction with his parents, his siblings, other family members, school, and community, all of these vectors of his social relationships, have a continuing effect upon him as he undergoes treatment while he, in turn, has a continuing impact upon them. These factors are inherently involved in any attempt to change either the child or his environment.

It is almost impossible to separate out any one set of factors in human dynamics and to examine them independently. Nevertheless, the tendency in child-guidance literature, until quite recently, has been to emphasize solely the therapeutic process with the child and to give relatively scant attention to the various social factors acting upon him. Consequently, in this paper the social factors involved in the determination of treatability will be stressed. Full understanding of such factors must depend upon an equally full understanding of the child's personality, the level of his development, and the dynamic factors involved in his present functioning.

The importance of social factors emerges as we examine the nature of the illness or deviation which brings the child to the clinic. There was a period in the history of child guidance when we believed that the discovery of the cause of a child's deviation would lead us to the cure. We tended, too, to seek for a single cause. As we frequently found the cause in a disturbance at an early point in the child's developing relationships to his parents, we took from this the direction for our therapy. Redirect the child's attitudes, remove the factors blocking his relationships, reestablish the balance and controls among the personality components, and cure would be effected. But the cure we sought was and still is evanescent in at least one of every three of our patients and often in two of three. There has been a remarkable consistency in these percentages in evaluatory studies whether of casework or psychotherapy, regardless of the theoretical orientation of the therapy.[1]

Most frequently the multiple social factors contributing to an illness have been neglected.

Medical pathologists have been increasingly questioning the concept of single causation even in analyzing diseases which have been found to relate to a particular microorganism. The principle of multiple causation and interrelation between individual and environment holds even more strongly in the etiology of emotional illness.

Cultural Differences

The same personality structure or pattern of behavior may be considered pathological in one culture and valued by another. The work of the cultural anthropologists has amply demonstrated this point, but few studies have been made of the variations among families within a culture in their capacities to tolerate various degrees of deviational behavior or even pathology. Yet clinical experience has shown how wide these variations may be. One family finds any degree of aggressiveness intolerable, and loses no time in bringing an aggressive child to the clinic. A second family is not affected by an equal degree of aggressiveness and comes to the clinic only when pressure is applied by a community agency, such as the school, which does not have the same tolerance for aggressiveness. In clinical practice we find difficulty in effecting change in a child's pattern of behavior if his family has a high point of tolerance in regard to, or actually values, that behavior.

Subcultures within our communities also vary in their tolerance for, or valuation of different types of behavior. For example, in the Jewish Community Services of Long Island the staff of the child-guidance services has noted consistent differences in the types of problems coming from its usual, middle-income Jewish clients and those brought by children referred to the agency from a lower socio-economic community by the New York City Youth Board. Particularly noticeable has been the difference in the degree of parental concern and anxiety over the children's difficulties—a difference based not in higher and lower valuations of children, but rather in the level of parental tolerance of deviant behavior. If the values of the subculture did not conflict sharply with the prevalent middle-class values of the community as a whole many of these children would not reach the agency.

By what criteria then do we determine whether a child is sufficiently ill or his behavior sufficiently deviant to take him on for treatment? The very determination of a state of illness depends upon the social situation, including complex interactions within and between the family of the child, his subculture, and the culture of the larger community.

Only recently studies have been undertaken of the relation of culture and social institutions to mental illness. The findings have been quite consistent in showing the universality of such interrelationships though the dynamics are still unclear. These findings indicate a consistent and significant relationship between social class and the nature of psychiatric disorders.[2] The evidence points toward the importance of social and cultural factors in the etiology, persistence, and modification of emotional and behavior disorders. Yet to what degree do we give them consideration in our diagnostic and prognostic procedures?

Purpose and Goals

Once we have arrived at a particular diagnosis—a diagnosis which is at least in part socially determined—the decision whether this illness is treatable does not automatically follow. Treatability, from a practical point of view, is a relative quality dependent not only upon the diagnosis but also upon a variety of factors external to the child. One of the most important of these is the purpose of the treatment agency. In a child-guidance clinic this is essentially a social purpose—to help the child live more effectively within the community. Treatability in any particular agency is further limited by the nature of the agency's staff, the resources available to it, and all too often by the attitude of the staff. The same child may be found untreatable in one clinic and treatable in a second. Some clinics have been established to treat only special problems. For example, a school clinic concerned primarily with the child's school functioning would not accept for treatment many children who function well in school but present serious problems at home, even if they are amenable to treatment. Similarly, the community clinic, with service for the entire community as its objective may often, because of limited resources, exclude as untreatable many children who could be helped were longer, more intensive, and more skilled therapy available.

Too frequently there has been a tendency to equate expediency or staff limitation with absolute treatability. For a long time therapists assumed that schizophrenic children were untreatable. However when special resources, including therapists with sufficient time, skill, and interest for such children were developed we learned that they could be helped. For instance, after meeting with a blank wall in trying to refer seriously disturbed children to appro-

priate treatment resources, the Jewish Community Services of Long Island obtained special funds for establishing a "long-term treatment project." The basis for the agency's assessment of treatability shifted as its purpose shifted. Once funds were made available with the precise purpose of developing treatment services for seriously disturbed youngsters living at home, the staff found that the determination of a child's treatability rested to a greater degree on the assessment of the family's ability to sustain the child and the community and school's ability to tolerate his behavior. The project is still too young for evaluation, but the agency has found that many seriously disturbed children can be helped into and to use treatment.

Child-guidance clinics also often exclude mentally retarded children or children with brain damage as "untreatable." Yet a few pioneering clinics and agencies, most of them established through the efforts of parents, have found that despite their intellectual limitation such children present emotional problems very similar to those of normal children and equally amenable to treatment methods.

What has been the reason for the exclusion of seriously disturbed or markedly deviant children from treatment agencies? This seems to derive from some absolute goal for treatment which rules out children incapable of attaining it. In the light of the social purpose of the clinic, the validity of such a procedure is open to question. Would it not be more in line with our purpose to recognize that few if any of our patients can reach an absolute goal and to offer treatment to enable children to function more adequately? While a retarded or other seriously impaired child may not be able to attain normality, if he can be helped to function more adequately in relation to others, if he can be helped to be happier, and if his parents can be helped to encourage and sustain his limited growth potential without pressure for impossible goals, would that not be an adequate base for acceptance by the clinic?

The Parents' Involvement

The problem of selection is particularly difficult in a child-guidance clinic because a child is dependent in so many ways upon important adults about him. Furthermore, a child's personality, still very much in the process of formation, is continuously influenced by what happens within his family. His way of responding to these influences has particular value to him. His symptomatic behavior may be a reaction against the overwhelming closeness of his parents and their inability to help him establish an independent self. Or it may be a defense against internal needs and impulses, a defense built up often as a result of the internalization of parental standards and values.

Often a child's symptoms may reflect his effort to obtain love and recognition by an identification with his parent's deeper but suppressed desires or conflicts. Since this behavior satisfies the parents' needs there is frequently a subtle encouragement of that behavior.

In one case a mother sought help with a 14-year-old daughter whose sexual precocity was alarming. The girl did not seem to progress at all in treatment until after the mother, in parallel counseling, became aware of her own repressed sexual needs which she tended to satisfy through her daughter's behavior. After each of her daughter's sexual experiences, she would question the girl in such detail that she led her on to the next step.

A child's symptoms also may reflect his confusion about, or his taking sides in, his parents' marital relationship. In situations of marital conflict a child often reflects the struggle between the parents and their effort to utilize him in that struggle. His behavior may also result from his reaction to the effort of either parent to find fulfillment through him of the needs which the marriage fails to fulfill. In many cases we find a mother turning to her child for the love which her husband does not show. In many others we find in a child's deviant behavior a reaction to his parent's attempt to realize frustrated ambitions through him. As we recognize the crucial role of family interactions in a child's behavior, the need for involving the parents in treatment becomes obvious.

Assessment of a child's treatability consequently must rest on the evaluation of the parents' capacity to involve themselves in the treatment experience and to work toward change in their relationship to each other and to their child. This determination of the parents' ability to change involves more than a diagnostic evaluation of each. A parent may be extremely disturbed and still be able, with counseling help, to find other ways of satisfying his neurotic needs than through his child. Where the parents cannot find other outlets for neurotic needs, where they must struggle against whatever changes are taking place in their child or constantly thwart them, therapy for the child obviously cannot be effective. As long as the parents are not involved, the child will resist treatment, unless he is old enough and has

sufficient ego organization to carry a great deal independently.

With the present state of therapeutic knowledge, we must conclude that cases in which pathology in all of the members of the family is interwoven and mutually reinforced are not suitable for selection in most child-guidance agencies as presently constituted. Yet we must face the fact that such "pathological families" constitute a major source of community disturbance and tend to be self-perpetuating. Breaking into these pathological families, discovering ways of concurrently treating each of the members while working at modifications of the modes of interaction constitutes one of the most serious challenges to the combined skills of social work and psychiatry. Fortunately most families of emotionally disturbed children are not "pathological" in this sense though they have problems.

Community Resources

Assessment of treatability must be based not only on the intake worker's intimate knowledge of his own agency but on a thorough familiarity with community resources and a sensitive and realistic understanding of family and community dynamics. In the community with no other resources, an agency may have to take on for treatment cases which in other communities might better be referred elsewhere. Moreover, while it is most desirable for a child to continue to live at home during treatment, some homes are so destructive and so resistant to change that the child might better be provided treatment either in a special institutional setting or after being placed in a foster family.

We must try to avoid, in considering treatability, either the automatic rejection of the idea of placement, or the too easy utilization of placement as a way of getting around the need for developing more fully our own treatment methods.

There is a real danger in the child-guidance field in the too complete restriction of cases to those for which the standard methods of treatment of child and parents hold promise. Witmer and Tufts, in a review of the effectiveness of delinquency-prevention programs, point out that child-guidance clinics, though originally established in the hope of reducing delinquency, through their intake policies have gradually excluded most delinquents from their caseloads.[3]

In view of the social responsibility of the child-guidance clinic, it is important to work toward a reversal of this trend. Somehow child-guidance clinics must find in intake procedures the means of accepting the more difficult children, and in therapeutic processes, the means of helping them.

Other Family Members

Sometimes in describing family dynamics, child-guidance workers seem to assume that the typical family is made up of an only child, a mother, and perhaps a father. We often tend to neglect the interactional roles played by various other members of the family: siblings, grandparents, aunts and other relatives and friends. While a child's relationships to any of these persons may further complicate his problem, often he can derive from them enough support and satisfaction to counteract to a significant degree the failures in the parent-child relationships. Bossard's studies of the large family point to the role which older siblings play in a child's development.[4]

In some cultural groups certain relatives outside the immediate family are given important roles in the development of the child -for example, the grandmother in certain matriarchally oriented cultures. One JCSLI case centered around a Negro child, living with his parents and a grandmother who took care of him while his parents worked. Though the mother and father seemed ready to become involved in working on their child's problem and the child seemed interested in getting help, they seemed unable to begin. After they canceled numerous appointments, the agency was about to close the case as "untreatable," but decided first to try to see the grandmother. When this woman came to the agency after considerable hesitation, she expressed a great deal of question about it and particularly about its Jewish connections. However, after expressing her doubts and gaining a sense of the agency's desire to help, her attitude changed. The child's parents and the child himself thereafter responded differently and eventually achieved considerable progress.

In another case a widowed mother and child who seemed to make a good beginning in treatment reached a point where they could not progress. The child seemed to be fighting his worker and the mother was not helping him. Throughout her interviews the mother had talked about her older brother who was enormously helpful to her and who also played an important part in the child's life. It became apparent that this man felt threatened by the agency and the family's involvement with it. The mother, feeling alone without his moral support, decided to withdraw herself and her child from treatment.

These cases illustrate the importance of considering not only relationships other than the parent-child relationship in determining "treatability," but also the possible effect of a particular plan of treatment on other members of the family. What will treatment of one child mean to his parents' relationships to their other children or to the child's own relationship to his siblings? How will the other children react to the frequent absences of the child and the mother?

In another case the JCSLI decided to discontinue treatment of one child until his mother could make plans for her other children, when it became obvious that their needs would be neglected if she made frequent trips into the city to visit the agency. In still another case, a child being seen at the clinic appeared to be helped, but his mother indicated in her interviews that she was displacing her hostility to a younger child who was now showing symptomatic behavior. As this development was discussed with her, the treatment goal was shifted toward helping her get therapy for herself and then for her child.

Another important consideration is the effect of a child's treatment upon his parents' marital relationship and other significant family bonds. Where mother and father disagree about the desirability of the child's undergoing treatment, where the father refuses to become involved in any way, or where treatment would have a deleterious effect upon the marriage, is it advisable to undertake it even if the child shows promise? In some instances it may be necessary to refer parents to a marriage-counseling service before attempting to treat their child. In others, skillful efforts by the social worker at intake toward involving the father in treatment may be effective.

Community Relationships

Sometimes in our consideration of significant family relationships, we tend to lose sight of the fact that a child lives in a community as well as in a family, that he attends school, that he moves in a world of his peers with its own special standards. The expectations and relationships these bring to him may have tremendous significance for treatment.

In one case in which a retarded child seemed capable of using treatment, his teacher, though related positively to him, projected all the blame for the child's difficulties upon his parents and lost no opportunity for accusing them. In her resulting anxiety the mother repeatedly castigated the child and tried to push him beyond his capacity. She could make no progress in her problem with the child until the agency, through bringing the school principal and teacher into the treatment plan, could effect a reduction in the teacher's pressure on her.

A child's friends and his neighborhood are also an important consideration in determining whether treatment might help—especially in low-income neighborhoods in which a child uses behavior unacceptable to adults to gain status with his peers. If no substitute for the peer group exists for him, the clinic's efforts to change him may be of no avail. Said one child, as the possibility of treatment was discussed: "I can't be a sissy and still be in the gang."

"The gang," in this instance, included all the children in the neighborhood. Since the mother could not find other housing accommodations the treatment plan had to include consideration of the effects of change in the child on his social relationships. If treatment, no matter how effective immediately, results in a child's isolation, its ultimate effectiveness might well be open to question. Fortunately the mother in this case could be helped to relate her standards to the realities of the neighborhood.

This problem of poor relationships often is a serious stumbling block in clinics working with delinquent children. Yet, the work of the New York City Youth Board has demonstrated that many very difficult children whose families showed little readiness to use clinic help were treatable in an agency that was willing to seek out the families in their homes and use the authority implicit in the community to encourage them to try treatment.[5]

The selection of cases for treatment is also affected by what the community is ready to support. Where the need is great and resources small, criteria for selection may be established on the basis of serving the largest number of clients with the least expenditure of professional time. But as the community reflects through additional funds its increasing concern for the seriously disturbed child and for the retarded and exceptional child, more attention is likely to be spared for difficult cases. Since resources are never completely ample, clinics must be careful to resist "the tyranny of the waiting list,"—that is, selecting for treatment only the most promising cases and leaving the most serious ones untouched.

The social purpose of child-guidance clinics would seem to require them to take on some of even the most "untreatable" cases in an effort to develop ways of reaching them. Similarly their intake policies should leave some time for participation in efforts to

prevent emotional disturbance. They need somehow to achieve perspective in dividing their energies among direct service, experimentation and study, and prevention. Moreover, the child-guidance field must recognize that the private clinic cannot fully meet the need for service.

Assessment of Social Factors

There is no formula through which to give relative values to the social factors warranting consideration in selecting cases for treatment in a child-guidance clinic. One factor may be offset by another. For instance, a child with a relatively minor emotional difficulty may be untreatable if his parents are unable to change in any way and if no other sources are available to him for obtaining recognition and support. On the other hand, some children with enough drive toward health may be able to profit from treatment even if the parents are quite resistive to help. For some, other forces in their families or in the community may be of potential support even though their parents have little to offer them.

Assessment of this array of social factors is an extremely complex task. The dynamics involved often are not apparent until the therapeutic process is under way. However, therapy actually begins when the child and his parents first come to the agency. In this sense the diagnostic procedures are steps through which many of those social dynamics can be reflected and tested out.

In addition to attempting to refine selection procedures, child-guidance workers may need to examine their therapeutic techniques more critically—particularly as they relate to family and social dynamics—and to experiment freely with ways of fulfilling their social purpose more adequately. A recent review of evaluation in mental health reported: "It is not uncommon for professional personnel working primarily in the area of diagnosis and treatment to assume that scientific evidence of results is more adequate or has progressed further in this area than in some of the other areas. In this review of the literature and studies in progress, such evidence has not been borne out."[1]

While child-guidance treatment methods are far from perfect, the techniques for selection remain considerably less refined. Ideally, selection is a process in which the worker's intuition and social purpose play important roles. Child guidance historically introduced the team concept as one way of dealing with the complex nature of its task. In the development of the field the purpose has tended to narrow to a psychotherapeutic concern so that in many clinics the potential contribution of the social worker to the team's operations has not been fulfilled.

With its long history of dealing with social factors, social work is in an ideal position for exploring the social dynamics affecting a child and for making significant contributions to clinical practice. Assessing social factors and dealing with them creatively in the process of therapy constitute the essence of social casework in child guidance. This was recognized by the Group for the Advancement of Psychiatry, which concluded a report: "If a social worker in a clinic, with or without specialized training as a psychotherapist, is regarded primarily as a psychotherapist, and carries activities said to be psychotherapy, then the contribution which he makes, though it may be valuable, is no longer casework, and the clinic team can avoid a functional loss only by the employment of a social worker who does casework."[6]

The social factors involved in the emotional illnesses and behavior disorders of children are so dynamically interwoven that exploring and dealing with them sensitively with social as well as psychological awareness, experimenting with them, and integrating them into the total therapeutic process constitute a challenge to social work. To meet that challenge, social workers in child-guidance clinics must reaffirm the "social" in their professional heritage, enrich it from the experience of social work in other fields as well as from the social sciences, and realize their potential contribution to clinical practice.

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Professions and agencies, State and county combine efforts in a Georgia project for . . .

COMBATTING MATERNAL DEPRIVATION

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MATERNAL DEPRIVATION—the failure of a child to receive "mothering" from the central figure in his life—is the target of a multidisciplinary, interagency project in a Georgia county. Jointly operated by the local health and welfare departments and juvenile court, with State stimulation and consultation, the project is aimed at developing a concentration of effort to protect children from maternal deprivation or to change situations likely to produce maternal deprivation.

The project is based upon the assumption that personality development is profoundly affected by early parent-child relationships. The World Health Organization's bulletin, *Maternal Care and Mental Health*, by John Bowlby [1] has been used as a resource in planning.

Preparation for the project began in the State Departments of Health and of Welfare 2 years before a specific county was selected as its locale. The need for a total service to families containing extremely neglected children had been recognized for many years by many public health and welfare workers in Georgia.

Three moves were made by the Health and Welfare Departments to launch the project: 1) its basic concepts were defined; 2) the factors likely to result in maternal deprivation were listed; 3) the observable indices for identifying children who are maternally deprived were developed.

The group which hewed out these definitions included two public-health nurses, a pediatrician, a school health physician, a psychologist, and a social worker. They found that previous concepts of maternal deprivation either had not been clear enough or were not communicable to the people of various levels of knowledge and understanding who would be needed to work in an action project. Eventually they arrived at the following definitions:

1. *Maternal deprivation* is the lack of continuous care by a mother or mother substitute during the period from birth through 4 years resulting in social and emotional isolation in the child.

2. *Care* is supplying not only the minimum physical needs for the child but also providing a continuing relationship with a single mother figure who can be identified by the child and others as the person fully responsible for his welfare and who gives the child the social and emotional stimulation and protection which makes it possible for him to: 1) respond to at least one other person; 2) achieve the developmental stage appropriate to his age and mental ability.

3. *A mother substitute* is either a paid or unpaid person who assumes the role usually carried out by the mother in the care of a child.

The factors which result in maternal deprivation were defined as:

1. Lack of a mother or mother substitute.

2. Absence of the mother or mother substitute for frequent periods of time extending beyond a few days.

3. Frequent changes in mothers or full-time mother substitutes.

4. Chronic physical or mental illness which frequently incapacitates the mother or mother substitute for prolonged periods of time.

5. Extreme mental or social deficiency in the mother which makes it difficult for her to care for herself outside an institution.

6. Extreme rejection of the child by the mother exhibited by attempts to give the child away without cause or making dangerous physical assaults on him.

The indices of maternal deprivation in young children were defined as:

1. Progressive wasting and emaciation, especially where there is no apparent physical cause.

2. A fixed continuous smile for which there is no appropriate cause.

3. Continuous, monotonous, patterned rocking or other self-stimulating rituals which are not interrupted by external stimulation of the type ordinarily attracting a child's attention.

4. A failure to react to outside stimulation as readily as most children and an isolated preoccupation without apparent external cause.

5. Anger or unusual excitement on the part of the child when isolation or preoccupation is interrupted by another person.

Original Design

As originally visualized the project was to be developed in the following stages:

1. Case finding of families in which maternal deprivation is suspected.

2. Geographical identification of areas of highest incidence, followed by study of sociological factors which differentiate high incidence areas from areas of low incidence. (No high incidence areas were found in the county selected.)

3. First stage screening and action on suspect cases by a screening committee representative of health, welfare, and juvenile court.

4. Home visits by nurse, child-welfare worker or court worker employing standard open-ended interviews followed by written reports. A plan to use volunteers for a survey in areas of high and low concentration of cases of maternal deprivation was later abandoned.

5. Second stage screening of home visit reports by the screening committee, to involve planned action on each case suitable for immediate decision and referral of those more difficult to evaluate to the maternal deprivation clinic.

6. Maternal deprivation clinic examinations of both mother and child followed by staff conference on each case referred to the clinic and recommendations for case management; the clinic team to consist of public-health nurses, social workers from the health and welfare departments, pediatrician, nutritionist, psychiatrist, and psychologist. A complete physical examination would be included for the child, but adults would be referred selectively to the Hospital Clinic.

7. Followup by worker making initial home visit, to carry out the clinic's recommendations.

8. Social action on factors identified in the high incidence areas.

Two sets of *case-finding techniques* were adopted:

1. Reporting of suspect cases by the personnel of the local health department, welfare department and juvenile court, as well as by private physicians, ministers, school staff, and police.

2. Review of public records including: a) juvenile court and superior court records on cases of abandonment and neglect; b) welfare department records; c) health department register of tuberculosis sanitorium patients having children under 5 years of age; d) health department general caseload records; e) vital statistics records of questionable infant deaths in families having other children under 5 years of age, of unwed mothers, and of families having more than 5 children; f) the County Ordinary Court records of commitments to State mental hospitals. Home visits made later to a random sample of the vital statistics categories indicated that these were not good prognostic categories in the county selected.

Two other preparatory efforts were made: 1) a series of educational aids was collected; 2) all current public-health nursing monthly narratives were reviewed for examples of probable maternal deprivation. The educational aids included: the films "Maternal Deprivation," "Grief," and "Somatic Consequences of Emotional Starvation in Infant"; a group of articles from various journals; and large quantities of the Bowlby bulletin.

A written description of the project was used with the films and public-health nursing narratives in informing the personnel of the State Welfare and Health Departments about it.

The Locale

Cobb County was then selected as the locale. The criteria for selection were:

1. The county was small enough in population to be manageable in a project of this sort.

2. It had a health officer who was interested.

3. His staff included a mental-health worker.

4. There was a child-welfare worker there.

Cobb County has a population of approximately 78,000 persons of whom 29,000 live in Marietta, the county seat. Prior to World War II, the county economy was almost entirely agricultural. Since then a rapid transition to an urban economy and culture has taken place.

When the project began the staff of the county welfare department consisted of a director, seven public-welfare workers, and, for a while, a trained child-welfare worker. The staff of the county health department consisted of a health officer, a psychologist, a nurse supervisor, and six public-health nurses, two of whom had had previous experience in a psychiatric setting. The judge of the circuit court had two probation officers on his staff.

These persons were all involved intimately in the project. In addition, they had available consultation from the staffs of the mental hygiene and maternal and child health divisions of the State Health Department, including a mental health nurse, a clinical psychologist, a psychiatric social worker, a pediatrician, and a pediatric nurse. Staff of the State Welfare Department also were available for consultation.

Preparing the County

State public health and welfare personnel met with personnel of the local health and welfare departments to present the plan. Afterwards a similar meeting took place with the personnel of the local juvenile court. After these three groups agreed to carry out the plan, approval was sought from the local medical society.

This process took patient and repeated explanations of the project's purpose and methods. Much careful work went into trying to help each group to understand what was meant by "maternal deprivation." The two tools that helped most in communicating the concepts were the nursing narratives which provided case examples of maternal deprivation, and the film, "Maternal Deprivation." The latter was particularly effective in providing agency workers with a practical criterion for making preliminary judgments.

One of the questions raised over and over, by both State and county personnel, was: "What are you going to do about these cases after you find them?" Or, as it was put locally, "Is this just another study? Are you going to find all these cases and then dump them back on the community, pointing out to us that we have a problem we already know about?"

These questions were pertinent and logical and required careful answers.

We explained that even though one of the agencies was already working separately with most of the cases, an evaluation of the total situation in each by all of the agencies concerned, together with a comprehensive plan for rehabilitation, seemed in order; and that if the agencies could have the help of a group of specialists in making their evaluation and of other specialized consultation not now available, their services to families might be more effective.

County Planning

The mental health worker of the county health department, a psychologist, became the coordinator of the project, and chairman of the Planning and Screening Committee. This was composed of the director of the local welfare department, a representative of the juvenile court, and the public-health nurse supervisor.

Very early in its existence this arrived at the following decisions:

1. Home visits would be made only by agency professional workers.

2. Participation of lay groups would be postponed until very late in the project.

3. For the community the name of the project would be changed to Emotional Needs of Early Childhood.

4. The only publicity given the project would be to the groups requested to report cases of suspected maternal deprivation.

The members of the committee shared the task of orienting the groups to be asked to report. They sent letters to all local physicians and ministers, containing one-page definition of the problem, a description of the project, and a request for names of suspected cases. In addition they used the film "Maternal Deprivation" as a part of a brief presentation to physicians, ministers, the police, and staff of county agencies.

The basic design agreed upon by the county at this point was a briefed version of the original plan. It included five stages or steps:

1. Case finding of families in which children may be suffering from maternal deprivation. Such families could be found in two ways—through agency records and voluntary referrals from community groups.

2. First stage screening: investigating the families referred and gathering the information which would be needed for second stage screening.

3. Second stage screening: identifying families in which children seem to be experiencing maternal deprivation and to be reacting with observable symptoms.

4. The operation of a maternal deprivation clinic in which an interdisciplinary staff team further evaluates the child and mother and makes recommendations for rehabilitating the family; the clinic to be held once every 3 to 6 months as needed.

5. Followup of the recommendations, carried out as far as possible by agency staffs, using all appropriate services.

Operation of the Project

The project began in May 1955. The first step was compilation of a list of names of children who might be suffering from maternal deprivation. The Planning and Screening Committee met several times as a whole between the initiation of the project and the first clinic, which was held in November 1955. In addition, various members of this committee met together several times to discuss individual cases. In general, the committee performed the following functions:

1. Pooling information on cases referred to the project and, when possible, making decisions about case handling without referral to the maternal deprivation clinic. This brought about an increase in inter-agency planning and action on all cases.

2. Deciding who should make the initial home visit to gather additional information for the committee's decisions on whether or not the case involved maternal deprivation, what inter-agency action had to be taken, and whether or not the family should be referred to the maternal deprivation clinic. In this procedure workers from each participating agency used the same standardized interview. The committee asked welfare workers to visit the families on their rolls and all the unwed mothers referred to the project. The public-health workers visited the families in which persons had been committed to mental hospitals, were on the tuberculosis register or were otherwise on their general caseload records. The probation workers visited a few families with whom they were already involved.

3. Review of the initial home visit reports in the second stage screening, followed by decisions for immediate action or referral to the maternal deprivation clinic.

4. Continual planning on all phases of the project.

5. Participation in the case conferences during the maternal deprivation clinic, to help the clinic team formulate realistic recommendations. This made it possible for the team to know at once whether or not an agency could take on the role suggested in the recommendations. Thus, in a few cases involving court action, the probation worker was able to say at the outset what the court's staff could and could not do. Similar explanations could be made by the welfare department director in regard to cases which needed funds or official welfare action.

The experience in Cobb County has revealed the need for the committee's assuming yet another function: periodic review of all cases. This would give the committee opportunity to decide how well the case is going, whether it should be closed or continued, and whether a re-referral to the maternal deprivation clinic is necessary.

Other community resources were also mobilized. Two pediatricians from the County Board of Health were asked to work on a voluntary basis with the project as representatives of the county medical group. Both participated in the clinics, and one also contributed much free medical supervision and service to children in the project and assisted in obtaining long-term hospital help in two cases.

Volunteer and civic groups also participated in the project. Members of the Junior Women's Club served food to the patients and the clinic staff, cared for the children while the mothers were being interviewed, and escorted the patients to the proper staff members. This club and other community groups also provided special financial assistance to a few families for whom agency funds could not be used, and obtained clothing, furniture and household items for them. Altogether some 70 people gave time and effort to the project.

It now seems clear that future projects should include a committee of civic and volunteer groups, the chairman of which should be a member of the Screening, Planning and Review Committee. The purpose of this community committee would be to carry out functions which the official agencies cannot handle. If a member of this committee participated in the clinic conferences he could indicate whether any community group could take responsibility for the parts of the recommendations not within the purview of the official agencies.

A Case Story

At this writing two cycles of referral, investigation, screening, clinic evaluation and followup have been completed. The families which were referred to the clinics were typical in one respect only—the fact that they each had many problems. We will, however, describe one to give a picture of the way in which the design applied, making several changes to preserve the family's anonymity.

The initial referral came from two sources: the records of the County Ordinary's Office, which showed the commitment of the mother to the State mental hospital; and the public health case records. The nurse knew this family of 2 parents and 8 chil-

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dren because she had been called in when the father was seriously ill and because the preschool children had received immunizations at the health unit.

At first-stage screening, the Screening and Planning Committee learned that neither the welfare department nor the court had had any dealings with the family. However, the psychologist who was chairman of the committee had, with one of the local health department nurses, helped the father arrange the mother's hospitalization.

The Nurse's Role

When the committee decided to admit this family to the project, the nurse who had already been working with it was assigned to make the "initial" home visit. Her report showed that the mother had first become ill several months after the death of one of her children. She had almost totally neglected twins who were born later. After showing increasing signs of disturbance, she had been hospitalized for about a year. Later, returned home as improved, she had continued to neglect the children and to be apathetic and withdrawn.

In her report, the nurse recorded the depriving maternal factor as the mother's illness, and the indices of maternal deprivation in the children as progressive wasting and emaciation with lack of responsiveness or emotional expression. Said the psychologist who visited the home at her request: "The child's skin was so loose on its frame that it felt as though it would come off in my hands."

The nurse had also noted that: although the father's income was over $5,000 per year, the house, furniture, housekeeping and food were extremely substandard; a teen-aged daughter was trying to take over the maternal role, but it was too much for her and her school work was suffering; the father was staying away from home more and more; the younger children were becoming problems at school.

At the point of second stage screening the Planning and Screening Committee reviewed the nurse's report, the State hospital diagnosis, and the psychologist's verbal report. The committee decided that according to the project's established criteria the children were seriously deprived and should be retained in the project and that the nurse should continue working with the family until the clinic could be held—2 months from then.

The most serious and immediate problem in this family was the physical condition of the twins. Under the supervision of the health officer and the nurse supervisor and with the consultation of the psychologist, the nurse was to try to obtain cooperation from someone in the family to prevent the children from dying. The father seemed the most logical person.

Because the family's income made the family ineligible for public assistance, the welfare department could do little for the family then. It agreed, however, as did the court, to step in if removal from the home became necessary because the children's physical condition did not improve.

In her early visits the nurse was accepted by the father, but was resented by the eldest daughter. As the nurse continued to visit the home and supervise the feeding of the children, the mother began to respond to her and to accept her support. In promoting this relationship the nurse consulted frequently with the psychologist.

As the time for the maternal deprivation clinic approached, the father requested the nurse to explain the procedure to his wife. Her attempts to do so, however, frightened the mother into temporarily breaking off her contact with the nurse.

Since the father drank excessively and had been undependable in carrying out the prescribed regime for his own illness, the nurse would at times try to work with the eldest daughter, who always seemed hostile and was obviously deeply ashamed of the family situation. The girl refused to bring the children to the clinic but the father after considerable vacillation eventually did so.

In preparation for the clinic, the nurse obtained a standardized medical history on the children, a routine pre-clinical procedure, and the psychologist tested the children with the Cattell Infant Test, also a routine procedure in respect to children under 2.

At the Clinic

During the clinic the father was interviewed by a social worker, psychologist, and the psychiatrist. However, he was not given the psychological tests for intelligence and personality factors—routinely given to mothers.

The children were examined by the nutritionist, the pediatrician, and the psychologist. The nutritionist plotted their physical development on a chart; the pediatrician made records of their physical condition and the psychologist gave them tests.

The social worker who interviewed the father was a child-welfare worker from the district office of the welfare department, the psychologist was in private practice in a near-by city, the pediatrician was a local physician, the nutritionist was from the regional office of the State Health Department. The nurse

who brought this family to the clinic was the one who had been making the home visits.

After their examinations, the members of the team met for a post-clinic conference to present and discuss their findings. The nutritionist reported that the children were retarded in physical growth. The pediatrician reported that in spite of this they were in fair physical condition, although still showing some effects of earlier severe malnutrition. The psychologist reported signs of slight mental retardation and severe emotional withdrawal.

The team members then agreed that this was a case of maternal deprivation, of moderate degree.

Recommendations and Followup

While space does not permit a presentation here of the diagnostic material which gave the team a picture of the family's strengths and weaknesses, these were the basis of the recommendations and the followup steps which rounded out a full cycle in the project's design.

The recommendations were:

1. Medical care for children.
2. Provision of emotional support and budgetary guidance for the father or the eldest girl, or both.
3. Strengthening the eldest girl's ability to assume the maternal role by teaching her infant and child care, meal planning and food buying.
4. A conference by a team member with the school personnel asking for additional consideration for all of the children, particularly the eldest girl.
5. An attempt by the nurse to develop a closer relationship with the mother and the eldest girl.

The nurse was selected to carry main responsibility for the case because of her involvement in it and the mother's recent positive attitude toward her.

Since attendance at the clinic, the father has taken the twins to a pediatrician, and they have continued to make physical and emotional gains. The nurse has visited the home every 2 weeks. She has established a good relationship with the mother, which seems to have given the family a sense of community acceptance, support and interest. As a result, the eldest daughter has developed very positive feelings toward the nurse.

The nurse has also had several conferences with the school personnel about the family, resulting in the school's taking special pains to help the children. The teachers have changed their attitudes considerably since, with the help of the visiting teacher, they have come to understand the family situation. All the children have shown marked improvement in their school work and in their attitudes toward school.

The nurse has also helped the eldest daughter with the family budget, given her information on food preparation, and arranged for her to have a visit with the nutritionist. In addition she has taken her shopping to show her how to buy the right kinds of food. The home economics teacher has given the girl instruction in food budgeting and home-making activities. The meals and the home environment have improved considerably.

The father has carried out necessary steps, such as taking the children to the pediatrician, only after much persuasion. Because of his long working hours and his rather negative attitude toward women, the nurse has not found it possible to give him the kind of support which would make his paternal role more effective. He seems to appreciate the help which is being given the family as well as the nurse's interest in his wife.

The eldest daughter has developed considerable strength and ability to manage and eagerly uses the help offered her. The family seems to have reorganized itself around her, thereby gaining some stability. This is not an ideal solution, but it has kept the twins alive and has resulted in very definite changes in the indices of maternal deprivation which were present when they were assigned to this project. They no longer show the signs of severe physical and emotional retardation which were so apparent when the mechanisms of this project were focused on them.

This family was average in its response to the project's attempts at rehabilitation. We have had one or two instances of very dramatic results and one or two which were unrewarding. In this case, an adequate, if not an ideal, mother substitute has been provided for the children, which may mean adequacy of the children when they are adults. There is, of course, the question of the effect of the heavy burden on the eldest girl and her outlets for normal teen-age life. This is a problem of which the project should remain aware. Nevertheless, the girl obviously feels much better off than she did before. She is less upset and better organized.

If the project is to give more effective help to both mother and father, the case will have to be reviewed by the Planning and Screening Committee and perhaps referred to another clinic for reevaluation.

General Information

Eighty-nine names were included in the original list of suspect cases compiled after the first meeting of the Screening Committee. However, the num-

ber of families seen in the first project cycle came only to 42 while just 8 actually went through the clinic process.

At the time of the first maternal deprivation clinic, 16 of the 89 families had not been found: 10 had moved out of the county; 8 had been eliminated from the project because the children were over the pre-determined age limit of 4 years 11 months; 13 had not been visited. All of the remaining families had been visited, by the public-health nurse or welfare worker, but 34 had not been referred to the clinic either because the home visits had revealed that the children were not showing symptoms of maternal deprivation, or because the difficulty could be met in some other way. In many instances an adequate mother substitute already was in the home.

In some of the cases accepted for the clinic major responsibility has been assumed by the welfare department, with or without help from the health department. In two or three cases, both departments and the court, plus the hospital, the local pediatrician, and several civic organizations and local merchants have played active roles in the rehabilitation process. The case described, however, is more typical, since it shows the way in which one visitor—whether health or welfare worker—assumes working responsibility for the family and uses the other specialists in the community, or the combined strength of the Planning and Screening Committee, or both, to help make her work more effective.

The presenting problems of the families referred to the first clinic show the kinds of situations with which the project has been dealing. They were:

A divorcee, Mrs. H., had a 4-year-old daughter who cried peculiarly all the time.

Mrs. D.'s 6-month-old twins had not gained an ounce during their first 4 weeks.

Mrs. A., who had been committed to the State hospital for the mentally ill before her daughter was a year old, was back home but still ill. The child seemed physically retarded and emotionally disturbed.

Mrs. B., who had periods of mental illness, admitted abusing her oldest child, a 3-year-old girl.

Miss J., an unwed mother with three children, had lost her aid-to-dependent-children grant after the birth of her second child. The little girl, whom she admitted neglecting, lay on a filthy pallet, unable to walk, until after her second birthday.

Mrs. G. and her husband had contracted tuberculosis before their first child was a year old and for the next 7 months both parents had been in the State Tuberculosis Sanatorium. Now the mother, with a new baby, was at home on bed rest. The older child cried almost constantly and was overaggressive.

Some of the home conditions were very bad. One report described a "mountain of trash and garbage in the middle of the floor." Another says: "A small pot was taken for the children to use so that there would be no further messing on the floor."

Following the first clinic many new referrals were made to the project. A second clinic, also including eight families, was conducted 6 months later. It now seems that about eight or ten families will be ready for a clinic evaluation every 4 to 6 months.

A Second Project

Currently, initial planning is being carried on in another county in an attempt to repeat the design of this project. With a population of approximately 9,000 people this county is more typical of Georgia's rural areas than Cobb County. Its local health department has three nurses who receive supervision from a health officer and a nurse director from the district health department. The circuit court has no probation workers. There is a three-worker welfare department. The superintendent of schools is on the Board of Health and also on the welfare board.

In this small county the project will actually be able to call on more resources, because of the availability of a child-guidance clinic located within the district health department. This clinic has a staff of two part-time psychiatrists, two psychiatric social workers and a psychologist.

The following changes or additions will be made in the new project:

1. The basic committee will be a Planning, Screening and *Review* Committee.

2. The civic clubs and other voluntary groups will appoint a committee to work with the project.

3. More assistance from specialists will be planned in the initial stages of home visit to help the staff visitors handle their anxieties in dealing with these families.

4. More frequent, scheduled consultation from mental health specialists will be offered personnel working directly with families.

5. Psychotherapy will be offered, selectively, to more mothers and children.

It is too early to conduct an adequate evaluation of the Cobb County project. However, the plans are already underway to make a partial evaluation within the next 6 months. Three or 4 more years will be needed for finding out whether this pattern of bringing already well-known techniques to bear on the problem of maternal deprivation deserves statewide development.

[1] Bowlby, John: Maternal care and mental health. Bulletin of the World Health Organization, Vol. 3, No. 3, 1951.

Do teen-agers need work experience or the protection of child-labor laws? "Both," says this discussion of . . .

YOUTH AND WORK

SOL MARKOFF

Executive Secretary, National Child Labor Committee

INCREASINGLY, citizens in various parts of this country are asking an insistent question: Are present child-labor laws doing more harm than good to our teen-agers? This is far from being an academic question. Last year bills were introduced in 4 State legislatures to reexamine or effectuate substantive revisions in existing child-labor laws. This year, when more than 40 State legislatures will convene, the movement will undoubtedly spread.

It will do no good for advocates of the status quo to point an accusing finger at critics of present laws and to characterize these individuals, unfairly and erroneously, as persons who want to exploit children for profit or to permit such exploitation by others. Undoubtedly a few selfish interests would like to see an undercutting of present standards in order to promote their own private profit. But happily, they are few. The real impetus for reexamination of the laws and for their revision does not come from "exploiters of cheap child labor" but rather from some educators, psychologists, juvenile-court judges, persons concerned about adolescent development, and others whose professional competence and unquestioned integrity cannot lightly be dismissed.

Have child-labor laws really progressed beyond the bounds of common sense as some of these critics have charged? And are they now hampering rather than promoting the welfare of young people by depriving them of opportunities for worthwhile work experiences?

If there is an affirmative answer to these questions, modifications would certainly be in order. Child-labor laws were meant to be shields used by society to protect children from industrial oppression: to give them opportunities to grow in decency and in dignity; and to afford them opportunities for educational advancement. They are not Holy Writ engraved in granite. They can and should be reviewed periodically and, if necessary, changed to meet the needs of the present in line with economic conditions and our ever-expanding knowledge about what young people require for wholesome development.

But what are the facts about child-labor laws today?

Some persons who have not studied child-labor laws closely are under the impression that these laws are concerned only with the labor of children. They do not realize that some of these laws seek to regulate, in some degree, employment of minors up to the age of 18 and, in some cases where there are physical or moral hazards involved in employment, up to 21. While regulatory provisions for older youth are necessary and socially desirable, the employment of young people aged 18 and 20, even though in hazardous work, is not, strictly speaking, "child labor," as that term is commonly understood.

In studying the facts, it would be well to draw a sharp line of distinction between "child labor" on one hand and "youth employment" on the other. A vast qualitative distinction separates the two. "Child labor" is a form of industrial cruelty to children, symptomatic of a society which is either economically backward or politically immoral. But "youth employment" is quite different. When young people are employed under proper working conditions and under responsible supervision, work can be a positive ingredient in their growth and can help in their social maturation.

In short, there is a period during which children

need the shield of child-labor laws to protect them against industrial oppression. There is also a point at which adolescents of employable age need worthwhile work experiences to advance their personal development, to prepare for careers, to stimulate their ambition. There is no essential conflict between these two ends. Young people today need both the safeguards of sound, sensibly administered child-labor laws and the active help of imaginative adults to assist them, at the proper time, in finding work opportunities suitable for their present needs and helpful to them for their future.

The Laws' Provisions

The critics of child-labor laws in general would do well to review their provisions. An analysis of State child-labor laws discloses that a considerable number of States have not yet met the minimum standards repeatedly recommended by the International Association of Governmental Labor Officials. In brief, these standards suggest a 16-year minimum age in any employment during school hours; a maximum 8-hour day, 40-hour week for all minors under 18; a 13-hour period at night during which any work is prohibited for persons under 16; and a similar 8-hour nighttime period during which work is prohibited for persons under 18.

However, in about half the States children under 16 can still leave school for work in some occupations; an 8-hour day for workers under 18 has been established in only 15 States; a maximum 40-hour workweek for persons under 18 is guaranteed in only a handful of States; long hours of nighttime work and hazardous occupations, such as the operation of power-driven farm machinery are still permitted in many States for youth under 18. In fact, hardly a State child-labor law meets the standards of the International Association of Governmental Labor Officials in all respects.

On the other hand, persons who "view with alarm" the deficiencies of these State laws and seek even stricter regulatory provisions may be tilting lances at windmills. The substandard provisions they deplore are perhaps not as decisive and as disturbing as they used to be, for voluntary industrial practices have, in many instances, with agriculture a notable exception, far outstripped the provisions of some child-labor laws enacted decades ago when labor standards were considerably lower than they now are. For example, while in most States today children of 16 can leave school to go to work, more and more employers are voluntarily establishing an 18-year minimum age for employment because they have found younger workers to be undependable, unproductive, and unequipped for current industrial processes. This fact is apparently not being recognized either by those who fear any reexamination of child-labor laws or by those who seek a lowering of the minimum age for employment. Letting down the legal bars to employment would probably not result in a substantially greater number of young people getting jobs in industry. The probability is that more youngsters would be out of school *and* out of work than there are now.

We have come a long way since the turn of the century, when one out of every six children was a child laborer. At that time about 800,000 children between the ages of 10 and 13 were at work, as were 1,000,000 aged 14 and 15. Very small children toiled for 10 and 12 hours a day in mine, mill, factory. Frequently, they gave up sun, air, play, and schooling—and sometimes even life itself—to the job. Such exploitation led to the great reform movements which have made such work illegal through State and Federal laws.

Even now every year a number of youngsters are still found employed in violation of some provision of a child-labor law. However, these offenses frequently result from misunderstanding of a law's provisions rather than from conscious, deliberate attempts to exploit children. Today, except in agriculture and a few other isolated pockets of our economy, child labor is happily a disappearing evil. This statement, which may be challenged by some persons, is based on the facts that State and Federal labor laws, although still deficient in some areas, have generally helped to outlaw for children and young people many of the kinds of employment that are detrimental to their health, schooling, and general welfare; that educational standards have been, and are still being, raised so that children are staying in school longer; that the mechanization of industry and the growth of the economy have raised the entry age in to the labor market.

At the turn of the century the average male made his entrance into the labor force at the age of 14.[1] Today, close to 97 percent of children under 16 years of age attend school.[2] The average young man does not enter the labor force on a full-time basis until he is between 18 and 19 years of age.[1]

As a result of dynamic social and economic changes, the child laborer of yesterday has largely been superseded by the teen-age jobholder of today, who works under much more favorable conditions. The differ-

ence is far greater than chronological age. The child laborer of yesterday worked more then he attended school. For today's teen-agers school is generally the full-time job (again, except for those in agriculture) and employment is a peripheral activity to be engaged in after school and during school vacations.

The diminution of the kind of child labor which existed in the past should not be construed to mean that existing laws should be scrapped or weakened. The welfare of children and young people requires that these laws be kept; strengthened where legalistic loopholes permit abusive practices; modified where they are unrealistic; administered wisely; and effectively enforced by adequately manned and professionally trained staffs. However, in such efforts society's attention should not be diverted from a corresponding need to do all within its power to promote suitable work opportunities for youth of employable age.

Under proper conditions, work experience can have many positive aspects for young people. It can help in the growing-up process of becoming weaned from parental protection and developing self-reliance—an excellent proving ground for moving toward maturity. However, if a job cuts into the adolescent's much-needed sleeping time or study time—jeopardizing either health or schooling—it should be discouraged. If a part time job leaves the youngster no time at all for extracurricular work at school, or for socializing with his peers, then he will be missing important opportunities in learning how to get along with his contemporaries.

If the part-time job the youngster takes is suitable and well supervised much can be added to his understanding of the world of work and to his own personal development. Through on-the-job experience, he can learn what is required of an employee, the nature of employer-employee relationships, the importance of good work habits and teamwork. He can learn to budget time by recognizing the importance of keeping a schedule and the preciousness of leisure.

Through exploration and discovery, he can get a clearer idea from his part-time job of what his vocational direction may be. He can begin to see the relationship between education and employment. The process of job hunting also provides an important experience. To find a job, a young person must know where and how to look. He must learn how to fill out an application blank and how to behave during the job interview.

In short, part-time job experience gives the youngster a realistic introduction to that major aspect of his life—employment—to which he will devote most of his waking hours and from 40 to 45 years of his

Child labor yesterday and today. Thanks to child-labor laws the little girl at the left, working in a South Carolina cotton mill in 1908, has few, if any, counterparts today. Agriculture is the one remaining area where many under-teen-agers can still be found working during school hours, as is the boy at the right dragging the 35-pound load of cotton.

life. A part-time job in itself, however, will not perform miracles. It will not necessarily persuade the potential dropout to finish high school nor will it "cure" the juvenile delinquent.

School Drop-Outs

The forces that pressure a youngster to drop out of school or commit delinquent acts are complex. Youngsters with such problems bring their maladjustments to the job. Undoubtedly cases can be cited in which an understanding employer helped a young person to make a better adjustment on the job than he did in school. However, there is good reason to believe that a troubled youngster in school will be a troubled youngster on a job. Employment per se will usually effect no marked change in his emotional disturbance; in fact, the employer may be even less tolerant than his teacher.

Yet the belief is widely prevalent that employment is the main solution to teen-age problems. Recently the Subcommittee on Juvenile Delinquency of the Senate Judiciary Committee "viewed with alarm" the lack of job openings for teen-agers, seeing it as a contributing factor in the youth-crime picture. Some persons in their concern to open up more jobs for youngsters regard child-labor laws as the major obstacle to such opportunities. These laws, they say, create "adolescent idleness," which they maintain is one of the major causes of delinquency. Their recommendations to correct this situation range from a "prudent loosening" of the child-labor laws to their complete abolition for persons of high-school age.

These advocates of reducing the restrictions of child-labor laws apparently do not recognize that any attempts to change these laws drastically in the name of opening up more job opportunities for youth would create a whole new set of problems. A weakening of child-labor restrictions will inevitably be accompanied by a complementary weakening of school-attendance regulations since these measures reinforce each other. If a youngster is required to be in school, he obviously cannot be at work during school hours. Yet the demands of our economy, with its increasing technical requirements, call for increasing levels of educational preparation, not less.

Then too, the dumping of youngsters into our complex and competitive labor market without guidance or supervision in choosing and finding jobs could also lead to trouble. Rather than learning discipline and responsibility, teen-agers who are out of school and out of work could increase the incidence of juvenile delinquency.

Even without legislative changes, this problem of unplanned school dropouts already exists. Under present compulsory-attendance laws, most States allow youngsters to drop out of school by the time they are 16. Of the million young people who dropped out in 1955 before completing high school more than half were unemployed, drifting, and discouraged, just waiting for "something to happen," according to the Senate's Subcommittee on Juvenile Delinquency.[3] It has been estimated that the incidence of delinquency in this group is 10 times higher than in the group of youngsters who complete their high-school education. If so many 16- and 17-year-old dropouts are without work, it can be assumed that the release of 14- and 15-year-olds from school, as has been advocated in some circles, would only compound the problem.

Nevertheless, supporters and administrators of child-labor laws should not shrink from reviewing them from time to time, for all laws need to be reexamined. If some specific provisions have become obsolete, or if the laws are unwisely interpreted, changes must be made. Regulations adopted with large cities in mind may be inadequate to meet the needs of young people living in small towns. Administrative procedures may need streamlining. Child-labor laws were designed to promote the well-being of children, not to hamper their development. Where they seem more obstructive than constructive reexamination can very properly be made without undermining their purpose.

Employment Opportunities

In some ways the current controversy about child-labor laws has blotted out other fundamental problems. An urgent one is how to provide more opportunities for desirable work experience for young people from 14 to 17 in an increasingly mechanized economy that has less and less need for their services. Another, just as urgent, is how to bring about the protective provisions of child-labor laws to many children and teen-agers now poorly safeguarded—especially the children of migrant farm workers who move with their parents from one community to another to help in the planting and harvesting of crops.

Attempts are being made by some secondary schools to meet the employment needs of their students by instituting school-work programs through which students spend part of the day at school and part in employment. However, these programs serve only a negligible portion of students. Some schools have also recognized that vocational guidance

and counseling is important in orienting the youngsters toward employment and work experience. Yet a recent survey by the Office of Education, U. S. Department of Health, Education, and Welfare, found that of the 24,000 schools studied only about 4,000, or 17 percent, had someone on the staff who devoted half or more time to vocational-guidance activities.[4] Many of the 19,000 counselors were without specialized training. They were responsible for working with about 3,500,000 students, making the ratio of service one counselor to every 521 students.

Unless our financially starved public schools receive better sustenance, it seems unlikely they can do much to remedy this situation. At present there is an accumulation of unmet needs for vocational-guidance and placement services. Yet it is anticipated that secondary-school enrollments will double in the next 5 years. Since school administrators will have to give top priority to plant and personnel problems, without Federal aid for education the problem will become more, rather than less, acute.

Today only about one-fourth of all students aged 14 to 17 carry part-time jobs. Even during the current period of prosperity more youngsters want part-time and summer jobs than there are jobs to go around. Our culture and economy are narrowing the circle of useful jobs for youth.

Recently the director of a neighborhood community center wrote to the New York Times:

"Every afternoon now after school is dismissed you can see hundreds of boys stopping at store after store and business concern after business concern asking for work. More often than not they reach home footsore, dejected, discouraged, and jobless."

The letter concludes with a plea to public-spirited citizens to assume responsibility for the job needs of its youth.

Some Experiments

In some localities beginning steps are already being taken in this direction. Various agencies are working together with the recognition that youth-employment problems are a community affair, requiring direct action by many groups. Such community projects that have already been launched vary greatly in size, scope, and sponsorship and range from the simple to the complex.

In Washington, D. C., the District Commissioners' Youth Council cooperated with the District Employment Service in developing a "Strictly for Teen-Agers" campaign, officially proclaimed for one specific month. The purpose was to develop odd-jobs pools for the summer employment of teen-agers ranging in age from 14 to 18. The pools were operated by 15 youth council area boards, using neighborhood recreation centers as their bases of operation. Young people interested in working registered for jobs at these centers. The area boards concentrated primarily on finding jobs for those between 14 and 16, slanting their job-promotion efforts at homeowners and local businessmen. The District Employment Service concentrated on the placement of 16- and 18-year-olds.

Cooperation came from a number of sources. Local business firms sponsored newspaper ads for jobs for boys and girls between 14 and 18 in their own neighborhoods. The National Bank of Washington circularized 50,000 bank patrons, asking them to "make an investment" in teen-agers of their neighborhoods giving them a chance to earn and learn. The odd-jobs pool idea proved so successful in getting summer employment for young people that consideration is now being given to extending the program through the school term to help teen-agers get part-time work the year round.

In Berkeley, Calif., several agencies have organized together a summer work project for 14- to 17-year-old boys. Known as the Workreation Camp, the project operates for 5 weeks during July and August under the administration of the State employment service, with the local board of education and the City of Berkeley jointly providing the finances. It offers the boys 4 hours of paid employment and 2 hours of supervised recreation during a 5-day week. Working in teams of 10 on school grounds and in city parks, the boys clear land, widen paths and trails, replant shrubbery, construct public barbecue pits and build bridges. The response to this program has been enthusiastic. The young people tackle their work assignments eagerly and efficiently. Parents are delighted with the constructive activities the project provides. The city reaps the benefits of civic improvement.

In Oak Park, Mich., a suburb of Detroit, a PTA committee was organized to contact local merchants and businessmen and to survey job possibilities for teen-agers. The survey concentrated on the suburb but also encompassed some sections of metropolitan Detroit. Through PTA efforts a number of young people were placed as packers in supermarkets, salesgirls in various types of stores, and clerical workers in business offices.

In New York City, the Police Athletic League sponsors an after-school job-placement program for

teen-agers of 14 and over. In Waterloo, Iowa, the YWCA, Community Chest, and State employment service jointly organized a youth summer-placement committee which found jobs for 267 youngsters.

In Lynwood, Calif., the Kiwanis Club sponsors a youth-employment agency, as does the Sertoma Club in Phoenix, Ariz.

In Elmira, N. Y., the Rotary Club decided to take steps to assist 14- and 15-year-olds in finding part-time jobs. The original idea was to organize a Rotary placement service. After discussing the proposal with local representatives of the State employment service, the Rotarians decided a cooperative arrangement was more practical and agreed to subsidize the salary of a qualified part-time interviewer who would operate within the employment-service offices. The interviewer's task was to establish liaison with Elmira's high-school counselors, to register applicants, to take job orders and to refer students to suitable part-time jobs. The project proved so successful that after 3 years, the employment service incorporated the service into its regular program.

In a number of cities in Kansas, campaigns, spearheaded by local service clubs and the State employment service, have been carried out to alert communities to the job needs of young people. Participating organizations have been the Chamber of Commerce, Lions, Kiwanis, Eagles, American Legion, and Veterans of Foreign Wars.

In Independence, Kans., businessmen financed five full pages of want ads in the local newspaper—78 ads in all, each featuring a different young jobhunter. These ads appeared in a Sunday edition late in May. Each contained a photograph of the applicant, his name, the name of his school and a brief description of his training and special interests.

In Chanute, Kans., all local employers received a poster and a covering letter from the Chamber of Commerce. The letter asked them to post a sign, which said in bold letters, "We are participating in JOBS FOR YOUTH—a Community Program—Hire a Youth This Summer by Calling the Kansas State Employment Service."

These activities make it abundantly clear that many community resources are available to meet the vocational needs of youth. What is needed is leadership that can mobilize more of them for the development of useful work-experience programs. Whenever and wherever it is recognized that youth-employment problems are a community affair, requiring community action, solutions begin to be found.

In developing suitable programs, sound and tested standards should be observed. These include: provision for a safe and healthful place to work, free of physical and moral hazards; some assurance that the young worker will be treated with sympathetic understanding and respect; good supervision and a chance to develop on the job; full protection of labor and social-security laws; and reasonable working hours. A summer job should not include more than 8 hours a day or 40 hours a week; and a part-time school-supplementing job not more than 3, at the most 4, hours a day. Moreover, the working hours should be so arranged that the young person has adequate opportunities for rest, study, recreation, family life, and personal development.

These goals are achievable, not alone by law, but through the voluntary and cooperative interest and action of employers, unions, schools, parents, community groups, and placement services. Our youth need and deserve this community effort, which should go hand in hand with efforts to encourage young people to get all the schooling they can and to complete at least a full high-school education.

A Grave Problem

In the current controversy over child-labor laws, it would be most unfortunate if the needs of children of migrant farm workers were overlooked. These children are subject to exploitation more than any in the land. In 20 States they can work at any age, no matter how young, and for any number of hours a day, no matter how many, even during school hours. As many as 40 States have no regulations whatsoever for children working in agriculture when attendance is not required in school.

In many ways these children are comparable to the children of 40 years ago who toiled in factory, mill, and mine. The Office of Education has estimated that 600,000 of them are not attending school at all. This is a situation which cries out for correction. It should not be forgotten in the current clamor over existing child-labor laws, which generally exempt them from all protective provisions.

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[1] *New York Times*, November 13, 1955.

[2] U. S. Department of Labor: The U. S. Department of Labor today, 1956.

[3] Youth employment and juvenile delinquency. Report of the Subcommittee To Investigate Juvenile Delinquency, U. S. Senate 1955. Report No. 1463 (p. 7).

[4] Jones, Arthur Julius; Miller, L. M.: The national picture of pupil personnel and guidance services in 1953. The Bulletin of the National Association of Secondary-School Principals, February 1954.

An examination of some socio-legal problems involved in . . .

THE FAMILY COURT

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RECENT YEARS have brought about an accelerated interest in the idea of a family court. This has been partly due to dissatisfaction with current methods of handling divorce and other cases involving domestic relations. It has also grown out of a desire to effect the proper combination of legal and social principles necessary to meet the rising tide of problems symptomatic of family breakdown—delinquency, neglect, divorce, nonsupport and the like. In some communities the obvious need to reduce the variety of courts handling issues concerning spouses and children has provided the momentum.

Nevertheless, the family court concept has been slow in being realized. The actual growth of social institutions and law always lags behind the theoretical base upon which they are built. Contributing to this in respect to the family court is resistance to change on the part of persons on the staffs of present courts and of agencies providing services to the courts who are afraid that their present roles will be upset. Some opposition has also come from the legal profession through judges and practicing attorneys who mistakenly assume that a fundamental conflict exists between social treatment and due process of law in approaching such cases. Some judges of juvenile courts have been afraid that the establishment of family courts would destroy juvenile courts—a result they would bring about only in the sense of structure, for the juvenile-court proceedings would become one of the functions of the family court.

It seems unlikely that the family-court concept will grow until some of the present opposition has been dissipated through better understanding of the full potential of the family-court idea.

An incomplete understanding of this idea has resulted in some places in the hasty creation of various forms of "family courts" and the grafting of marriage-counseling services onto existing courts. These moves have been "hasty" in the sense that the structures and procedures of law and social-work practice have been set up without careful evaluation of the roles they will play. This partial approach has added confusion, increased costs through duplication of services, and, perhaps, postponed the establishment of integrated family courts.

Such confusion has added to the resistance to the family-court concept and has been interpreted as conflict between the legal and social points of view. This conflict, more imaginary than real, stems not from a clash of principles, but from the limitations to the development of some of these principles and a lack of understanding of their full implications. Both the legal and social-work professions need to evaluate and recognize the contribution each can make to bringing about a truly integrated family court. Thus they can lay a basis for reshaping and refining the judicial and social-service processes

Examination of court operations as they affect children is a continuing process within the Children's Bureau. Therefore readers' comments on the points made in this article are particularly invited.

necessary for the informed handling of the many cases needing the court's service.

Through a statement of the function and philosophy of the family court as they see it and a discussion of some of the issues involved, the present writers hope that they can help to dispel some of the confusion that stands in the way of a true realization of the family-court concept. They would also like to point out that while a family court as described in the following pages would be a desirable agency for every community, whether it is readily attainable for any particular community depends on a variety of factors, including the community's receptiveness, the availability of the professional staff required, and the present structure of the judicial system.

What Is a Family Court?

The three primary elements distinguishing the family court from other courts are: jurisdiction; the use of modified and special procedures; and the use of information secured by independent study—that is, material gathered by a person attached to the court but not a party to the proceedings, thus assuring impartiality of the report.

The family court differs from the traditional juvenile courts and domestic-relations courts chiefly in jurisdiction. All juvenile courts and domestic-relations courts, as well as some other types of courts, have jurisdiction over issues which would be within the family court's jurisdiction; but none of these courts have jurisdiction over all the issues that would necessarily come within the purview of the family court.

A family court should have jurisdiction over:

a. Children alleged to have violated any State law or municipal ordinance or to be habitually incorrigible.

b. Children alleged to be neglected.

c. Proceedings for termination of the legal parent-child relationship.

d. Adoptions.

e. Proceedings for appointment of a guardian of the person.

f. Proceedings to determine disputed or undetermined custody of a child.

g. Petitions by a parent for a change of legal custody.

h. The transfer of legal custody of children alleged to be mentally defective or mentally ill.

i. Actions against parents or others charged with desertion or abandonment of a child.

j. Actions against parents, or other adults having a continuing relationship with a child, who are alleged to have committed an act forbidden by law or ordinance or to have failed to perform an act required by either with respect to the child.

k. Actions for support, including support of minors, spouse, parent or other relative, and children born out of wedlock, including actions under the Federal Uniform Reciprocal Enforcement of Support Act.

l. Proceedings to establish paternity.

m. Charges of simple assault and disorderly conduct involving members of an immediate family unit.

n. Proceedings for divorce, annulment, separation.

o. Proceedings to confer rights of majority on a minor.

p. Actions under the Interstate Compact on Juveniles.

While the family court adheres to basic legal principles and proceeds in a way which assures due process, it does so in an informal manner rather than through adherence to traditional rules of criminal and civil process. Moreover, through its screening procedures the family court in some cases exercises its power to determine whether court action is appropriate or whether the case should be referred to another agency in the community. Therefore the community must make available a variety of services and facilities if the court is to be fully effective.

Through the tool of independent study the family court, within the framework of due process, calls on the knowledge known to the medical and behavioral sciences in reaching its decision. This means it must have specialized staff trained for gathering and interpreting such material.

Why a Family Court?

The need for change in court jurisdiction, structure, and procedures is indicated not only by the increase in divorce, delinquency, and neglect, but also by years of experience in handling cases of these types, a more systematic review of this experience, and greatly increased knowledge of human behavior. In most of our communities today any examination of the judicial structure and processing of cases involving children or marital problems will provide strong arguments for the placement of jurisdiction over all such cases in one court. In some communities the types of actions outlined on this page may be heard in two or three courts. In others, especially our larger metropolitan centers, they may be divided among six or seven different courts.[1]

People in need of court services often do not know to which court they should turn. Each court may have different policies and procedures, resulting often in inconsistencies in handling or in ultimate decision. The question of jurisdiction itself may involve a complicated, time-consuming decision.[1] In many instances, each of the courts operates quite independently of the other and as a result two or more courts may simultaneously be working at cross purposes, each unaware of the current or previous action of the other. The wastefulness of such an arrangement is obvious. Neither the interests of the parties in the case nor that of society are effectively served.

At the present time there is, and undoubtedly for some time to come there will be, a serious shortage of qualified staff to operate existing court programs properly. While this problem cannot be solved merely through changes in judicial organization, the concentration of available staff in one court would permit its more effective use by reducing administrative costs, promoting better supervision and greater coordination of effort, eliminating duplication, creating a better opportunity for interchange of ideas, and determining priorities in expanding and developing services.

Specialized Services

Often children are pawns in bitter custody battles in which their interests are overlooked as parents fight to get even with or punish each other. In most divorce cases, even in uncontested cases, the court has no way of knowing whether the petitioning spouse is a proper person to have custody of the children. Yet, as a rule the petitioning spouse is given custody on the assumption that he is not at fault. Controversies with respect to the right to visit children, support, and custody often continue for long periods. If children are to be adequately protected, all of these determinations call for objective knowledge about the case through the use of independent studies.

The court handling cases involving children should constantly have in mind the rights and responsibilities of parents since these are paramount in our society. The State can enter into a family situation only when it becomes apparent that the parents have been unable to carry out their responsibilities. However, the court must also remember that the community has a responsibility to protect children and to assure that they are properly supported. Therefore, in the interest of the public as well as the children, the judge needs all the relevant information he can get from a person not involved in the proceedings and qualified by training and experience to secure it objectively.

Since family court jurisdiction includes all cases usually handled by a juvenile court, it needs the same services which are deemed necessary for the effective operation of a court for children. These include social, medical, psychiatric, and psychological services as well as specialized facilities, including diagnostic centers, shelters for detention and temporary care, and various types of foster homes. These must either be a part of the court structure or of community agencies to which the court has access. Since both the use and organization of such services in children's court have been covered elsewhere,[2] they will not be discussed here.

Since the family-court jurisdiction includes among other actions divorce, annulment, separation, and problems relating to custody, support, and visitation of children, the question arises: what kinds of services in addition to those available to a juvenile court does it need? Marriage counseling is probably the only different type of service a family court requires. However, there should be a difference in the use of specialized services in certain domestic-relations cases, such as divorce or annulment, from their use in juvenile-court proceedings.

Little has been written thus far about when and how such services can be utilized effectively in the court process without violating legal principles or due process of law. The use of these services must be woven compatibly with legal principles and process if the court is to take full advantage of the contribution of the social sciences and at the same time maintain the judicial system basic to our society.

Specialized services might make a contribution to the handling of divorce cases in two ways. One would be by providing *social studies* to guide the court's decisions regarding custody, visitation and support in order to protect the interests of the parents and children as well as society. The other would be by providing *marriage counseling* prior to the granting of a divorce.

Social Studies

The function of social studies in certain types of domestic-relations cases such as custody, support, and visitation is similar to their function in children's courts—that is, to guide the court in making decisions in which the interests of children, parents, and society are directly involved. Contrary to another expressed

point of view,[3, 4] the writers of this article believe that the social study should not be used by the court in determining whether a divorce, annulment, or separation should or should not be granted since such use would conflict with sound judicial process and legal principles.[5]

Grounds for Divorce

Examination of the legal aspects of marriage and divorce is necessary to show the reasons for this position. In our society marriage is regulated by law. The conditions under which marriage can be dissolved are also determined by law. While considerable difference in what constitutes grounds for divorce exists among the laws of the various States, all States granting divorces use statutory grounds as the basis for the action. In other words, one party has a legal right to divorce if he can prove that certain statutory grounds exist.

In spite of the many recognized weaknesses in present divorce laws and procedures, statutory grounds must be recognized as the only realistic and acceptable basis for the termination of the marriage contract in the United States today. What would be the alternatives?

One alternative would be for society to allow divorce to become a purely personal decision between a husband and wife.[6] This would seem to be poor social policy for the United States. It would lead to a definite weakening of the family as the unit of society and would certainly not provide adequate protection for either society or the parents and children involved.

The other alternatives would be to change divorce from a matter of right under certain statutory conditions, to a matter of the court's discretion. Under this proposal, with or without the recommendations of specialist personnel, the court would decide whether or not the divorce should be granted.[7, 8] The dangers here are that under this system the granting of a a divorce could become dependent wholly upon the personal attitude and conviction of the judge, or the judge and his staff. Few people would want to put themselves in the position of having their right to a divorce depend upon whether a single individual thought it would be good or bad for them.

The existence of statutory grounds for divorce means that the granting of divorces does not rest on what an individual thinks is best for all concerned, but on a showing that the statutory grounds exist. Therefore, the social worker's role (or the role of other personnel used to make social studies) should not be to help the judge decide if the divorce should be granted. In fact, the social study should not be used in the adjudicating process until *after* the decision about divorce has been made and collateral issues such as custody and support are being considered.

This does not imply that society should not be concerned with the preservation of marriage and family life. It does imply, however, that its concern might be better expressed in other ways, such as by tightening requirements for marriage, giving better preparation to young people for family life, and making marriage counseling services available when problems first begin to appear.

In some States legislation has been introduced to provide for independent investigations before the decision on divorce to determine whether collusion exists in such actions. Such investigations, if necessary, should be the function of a person trained for such purposes and not the function of a social worker.

Use of Social Study

The use of social study in custody cases raises a difficult question. To what degree does society need to intervene in custody problems?

Requiring social study in all custody determinations would be to assume that all parents seeking a divorce were incapable of planning for their children. The fact that two people cannot get along as man and wife does not necessarily mean that they are not concerned about their children and are incapable of arriving at a custody agreement which would be in the children's best interests. When parents have the capacity to plan adequately, society, as represented by the court, should acknowledge that capacity. On the other hand, some safeguards must be established to assure protection of the children and the community.

Cases coming before the courts provide clues for a differential use of the social study in custody determinations.

When custody is contested, a social study should be mandatory to enable the court to have adequate information for determining which, if either, parent should be granted custody or whether it should be given to another person or to an agency. The decision that neither parent should be granted custody should be made on essentially the same basis as removal of a child from his parents in a neglect proceeding—their inability to meet minimum standards of parental responsibility.

Agreements as to custody submitted to the court by

the parties in a divorce action should be given every consideration and should be approved unless there is some indication that the parent to receive custody is unable to meet minimum parental standards. In cases involving agreement by default, in which the court has reasonable grounds to question the fitness of the parent to receive custody, the court should have the power to order a social study. All custody cases, therefore, including those where an agreement has been presented, should be carefully reviewed by the court. This review should include a search of the court's records for past contacts with the family, the use of information from social-agency contacts, and an evaluation of the information brought out at the divorce hearing, as well as of the parents' plans for the care of the children involved.

The court should be permitted to review the necessity for a social study in regard to other aspects of the case, such as support and visitation, at the same time it is reviewing custody. For these purposes it should be authorized to use any information about the family at its disposal, including information from its own files arising out of previous proceedings, such as those involving delinquency or neglect.

Since the family court includes the jurisdiction of the juvenile court and since the use of the social study in certain domestic-relations issues such as custody and support is essentially the same as in the juvenile court—as informational background for making a judicial determination—the specialist personnel making social studies should be administratively attached to the family court, as is recommended for juvenile courts.[2] Moreover, since the judge relies upon information contained in the social study when making a decision and since the parents are entitled to know the basis of the decision, that information should also be available to the parents.

Marriage Counseling

The term marriage counseling is used here rather than conciliation or reconciliation since it more accurately describes the nature of the service required. Its function is more than, and may be different from, bringing about compromise or reconciling two points of view. As Judge Paul W. Alexander of Toledo, Ohio, points out, marriage counseling is not a process where "fools rush in, knock the couple's heads together, and proudly send them home 'reconciled,'"[9] but rather a treatment process which often continues for many months.

Factors contributing to divorce are often complex and hidden. Frequently, the causes given are only the symptoms of deep-seated problems. Moreover, "where marriage counseling is involved, whether by a social worker within the general framework of casework, or by members of the other professions most usually involved—psychology, sociology, medicine, or psychiatry—it is generally recognized that special skills, background, and experience over and beyond routine graduate professional training are required for adequate and successful performance on the part of the marriage counselor."[10]

Some persons have advocated that the parties in a divorce action be required to submit to marriage counseling prior to the filing of a divorce petition or that a divorce be granted only after such services have shown that a marriage could not be saved.[10, 11]

Few people would question society's interest in a problem as serious as divorce, but for several reasons it is questionable whether society should regard the divorce problem of such a nature as to warrant the intrusion upon personal privacy through compulsory counseling. The questioning relates partly to the aforementioned statutory right to an action for divorce in our society and to the methods by which society can most effectively preserve family life. However, it also involves some additional points.

Because it eliminates the screening of cases for treatment, compulsory counseling is extremely wasteful of staff time, usually not even sufficient to meet the voluntary demands for counseling.

Persons who seek counseling voluntarily are more likely to be those who are interested in preserving their marriages and therefore to be those having a better treatment potential. Where counseling services are available for voluntary use, the imposition of compulsory services as a prerequisite to court action would appear to require a compulsory acceptance of an unwanted service. Moreover, the denial of immediate access to the court by requiring submission to compulsory marriage counseling may raise a serious constitutional question.[12]

Information secured from the parties during the marriage-counseling process should, unlike that in the social study, be privileged—that is, immune to disclosure without consent of the party providing the information. Thus its use in the court hearing, unless assented to by the parties, would be prohibited. This protection is necessary, for many persons would be reluctant to enter into the marriage-counseling process if the information divulged could be used against their interests.

Some persons advocate placing marriage-counseling services in the court. One argument for this

viewpoint is that at the time when a divorce is applied for society has the first real indication of family breakup. Another argument is that courts are in a better position than other agencies to get money to finance such services. Another is the ability of the court to use its authority in bringing about use of marriage counseling. Still another argument is that since the court has specialist staff to make social studies it should also provide marriage counseling. All these arguments are open to serious question.

A Community Service

There are compelling reasons why marriage counseling should be placed *outside* the court:

1. Marriage counseling is not related to the judicial function as it is not used in the adjudicating process.
2. In a number of communities it is already being provided by other agencies. In many others, agencies exist which could provide an appropriate setting for this type of service.
3. People should not have to resort to legal process to secure marriage-counseling service.
4. Since in many cases divorce is a symptom of a home already broken, obviously marriage counseling should be available to people long before they are at the point of taking legal action. In fact, helping people to meet domestic-relations problems, also requires the availability of premarital and post-divorce counseling as parts of a comprehensive marriage-counseling program which can be provided by one staff. To require people to apply to the court for a service which may have no relation to court action, or to duplicate a service already in the community are both undesirable alternatives.
5. The judicial and administrative functions, which are the essential responsibilities of a family court, constitute a large and difficult task. Every attempt should be made to avoid burdening the court with extraneous functions.
6. People who might make use of marriage counseling available elsewhere in the community might resist the idea of going to a court for such help.
7. A marriage-counseling service having broad community sponsorship could expect greater financial support and have a wider base upon which to build community interest than one established as merely another division of judicial structure. The court can and should assume responsibility for pointing out the need for such a service and for supporting its development in the community.
8. Separation of marriage-counseling services from the court process should lead to clarification of the functioning of the family court in relation to that of other agencies in the community.
9. The attachment of marriage counseling to the court complicates the problem of privilege in the information obtained in the marriage-counseling process. If the same worker or agency provides marriage counseling and also does the social study for the court, a serious problem of professional identity is raised for the worker. If marriage counseling is to be effective the clients need to know and accept the fact that the information they give is confidential. Can they be expected to believe this if they know the same worker or another worker on the court staff is going to present a report to the court upon which the judge may make a decision about custody, support, or visitation?

While marriage-counseling services should be provided by a nonjudicial agency and the use of such services should be voluntary the court process in handling divorce should provide for exploratory interviews with a twofold purpose: (a) to acquaint both spouses with the personal, social, and economic problems which they and their children may have should a divorce be consummated; (b) to provide them with information about resources which might help them meet their problems and to assist them in referral to the appropriate agency. While this procedure might require several interviews and is comparable to the preliminary screening process at intake in the juvenile court, it should not be confused with marriage counseling.

The Role of the Attorney

In our society persons facing a loss of rights (whether property, freedom, or custody of children) need the help of a person who has an understanding of law and legal principles and procedures, to guard their legal rights and to present their case in court in the most favorable light. Because of his training, the attorney has traditionally filled this role. Of almost equal significance is the advice attorneys give clients which may eliminate the necessity for court action.

Any innovation in court procedure entailing the court's use of facts gathered independently by persons who are not involved in the courtroom procedure is a departure from tradition and might be looked upon in some quarters as supplanting the attorney. Actually there is no valid foundation for this concern. No amount of independently collected

and evaluated background material could replace the need for the attorney in insuring the safeguarding of legal rights.

If the specialized services of the court are constructed and used as suggested here, little if any change would take place in the traditional role of the attorney in court—certainly none as far as his role in relation to the divorce action is concerned. In regard to the collateral issues, such as support or custody, attorneys would have the benefit of the information contained in the social study. This should shorten the hearing process and enable the court to make a decision on the basis of objectively presented and evaluated information, taking into consideration the general welfare of the children involved. Most attorneys would probably favor these results.

Actually an attorney can increase his contribution to many of his clients by referring them to appropriate community services for guidance or other help before they get to court. When a troubled spouse comes into his office an attorney can, in addition to considering the legal problem his client faces, also give (and many do) real help in regard to the client's personal problems. He can act as a buffer against an ill-advised, hasty decision made under emotional stress by discussing the social and economic implications of the client's request; and then can refer the client to his family pastor or doctor or to any agency providing marriage counseling. Since this type of service involves a considerable expenditure of time, the attorney may expect a reasonable fee for it.

Attorneys are becoming increasingly aware of the social problems involved in divorce actions and are making greater use of community agencies. Many would welcome and use a marriage-counseling service for their clients. Referral procedures should be developed jointly by the agency providing the service and the local bar association. Such procedures should, among other arrangements, provide for the agency's notifying the attorney of whether the case has been accepted or not, and for referring the client back to him for legal service at any point necessary and for notifying the attorney in regard to the outcome of the case.

In Summary

Pressing legal and social reasons call for the establishment of family courts. The legal arise from the need for a more effective judicial organization for the administration of justice in relation to interpersonal family problems. The social grow out of society's concern for the protection of children and family life and recognition of the need to use the scientific knowledge and skills available to accomplish these objectives.

It seems doubtful whether much progress will be made until the various professional persons involved—judges, social workers, attorneys, doctors, and others—more carefully think through the issues and problems involved, some of which were presented in this article. In moving toward the establishment of a family court, it is important for a community to give careful thought not only to immediate problems, but also to long-range objectives, including the development of the broad, comprehensive, and coordinated community programs which are necessary to strengthen family life and thus to solve at least in part, the serious problem which divorce presents in our society.

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PROJECTS AND PROGRESS

A Report From Camp Kilmer

Exactly 24,512 Hungarian refugees—including about 4,300 children under 15—had arrived at the Joyce Kilmer Reception Center at Kilmer, N. J., by February 11, 1957. Of these, 23,153 men, women, and children had already departed from the center for homes and jobs throughout the United States; 1,359 were still in the center waiting for completion of resettlement plans.

Most of the children who pass through the center are with their own parents or close relatives. There are no small orphans among them. There are, however, a number of unaccompanied adolescents, aged 15 to 18, who were participants in the fighting in Hungary and are here seeking asylum. Some are on their way to join relatives or friends, but others have no connections in this country. In their ways they seem much older than young people of comparable ages in this country.

The process of clearing and preparing the refugees for departure to normal American communities is carried on by a number of governmental and voluntary agencies, which are provided with office space and other facilities by the United States Army. Coordinating their efforts is the President's Committee for Hungarian Refugee Relief.

The Army provides food and sleeping quarters for the refugees while at the center, as well as emergency medical, dental, and hospital care. Although the barracks are makeshift quarters for family life, they are clean, and sleeping compartments are curtained for privacy. Every barrack has a Hungarian-speaking GI ready to interpret and help. Amenities have also been provided, such as high chairs for toddlers in the cafeteria, warm water to bathe babies, English classes, a school for younger children, and a gymnasium for the teen-age volley-ball and soccer enthusiast.

Few people stay in the center more than 10 days. On arrival each refugee is examined by doctors of the Quarantine Service of the Public Health Service, U. S. Department of Health, Education, and Welfare, and is interviewed by representatives of the Immigration and Naturalization Service, Department of Justice, and of the Bureau of Customs, Department of the Treasury. Each prospective wage earner also sees a representative of the U. S. Employment Service, Department of Labor, who works out an appropriate

Two children at Camp Kilmer

job classification for him, following which a representative of the Social Security Administration, Department of Health, Education, and Welfare, issues him a social-security number.

Final plans for settlement, however, are made by the national voluntary agency which has agreed to sponsor the refugee. The agency tries to match the refugee's training, experience, and wishes with offers of jobs and housing. The national sponsoring agency also arranges for transportation to the place of resettlement and accepts responsibility for helping the refugee and his family should the local job-offerer renege on his offer.

The voluntary organizations have also taken on the responsibility of supervising and finding homes for the unaccompanied adolescents. About 60 of these have already been placed with relatives or with non-related families who are providing for their maintenance. Most of them are planning to resume their high-school or college studies. Arrangements for university scholarships are made through a subcommittee of the President's Committee for Hungarian Relief, assisted by the Institute for International Education and World University Service, an arrangement set up to channel the offers of scholarships which have been received from educational institutions. In many of the adolescent placements the national sponsoring agency has arranged with a local voluntary welfare agency to carry on continued supervision, with the national sponsoring organization standing ready to take over responsibility should a breakdown in plans occur.

Those agencies accepting the load of sponsoring responsibility are: Church World Service, International Rescue Committee, Lutheran Refugee Service, National Catholic Welfare Conference, Tolstoy Foundation, United HIAS Service, and the United Ukrainian-American Relief Commission.

Cooperating agencies with representatives at the center include: The AFL–CIO; American Red Cross; Hungarian National Council; National Academy of Sciences; New Jersey Governor's Committee for Refugee Relief; and the World University Service.

Besides the Federal agencies already mentioned, the Department of State and the Department of Health, Education, and Welfare (as a whole) are also represented at the center. The latter calls on its operating agencies—such as the Children's Bureau, Public Health Service, Office of Education, Office of Vocational Rehabilitation, and Bureau of Public Assistance—to help plan for meeting the human problems which arise.

Among these problems are health problems which occur in any normal population group but which are not usually present among newly arrived quota immigrants, who have had to pass rigid medical tests before being allowed entry. Since some of the normal immigration procedures have been waived for the Hungarians brought to Kilmer (who thus are "on parole," as aliens without status) some of them have turned out to have illnesses, such as tuberculosis, requiring prolonged hospitalization. In order to prevent members of a family from being separated by long distances through resettlement in one area and hospitalization of a sick member in another, plans have been worked out for arranging for

hospital care of sick persons in or near the community of their family's resettlement. In such instances hospital costs are paid by the Immigration and Naturalization Service.

This is but one illustration of the efforts made to keep families together. Unaccompanied adolescents who are brothers and sisters are placed with the same foster families, if possible. Even the selection of universities for scholarship students is related to the housing and resettlement plans of their parents.

Everything does not always work out as planned. A few refugees have come back to the center after a short period of resettlement, with tales suggestive of exploitation—such as the young pregnant widow whose local sponsor insisted she give up her baby for adoption. A handful of refugees have already been returned to Europe at their own or this Government's request. But such occurrences have thus far been rare, and on the whole the atmosphere at the center is one of optimism and hope.

—*Martin Gula*

Safety

Studies of accidents occuring to children and youth are part of a comprehensive program for accident prevention planned by the Public Health Service, U. S. Department of Health, Education, and Welfare. The program was created at the beginning of the current fiscal year to take the place of a more restricted program on prevention of home accidents. Other units of the Department cooperating in the program are the Children's Bureau, the Office of Vocational Rehabilitation, the Food and Drug Administration, and the Office of Education.

Concerned with the basic factors in the causes and prevention of accidents, the program includes collection and analysis of data; training of persons concerned with accidents, such as the staffs of local health departments; information services; experimental and epidemiological studies; program demonstrations; consultation to official and voluntary agencies; and aid to health departments in evaluating and setting up statistical procedures. Special attention is being paid to safety in housing. . . .

Under Public Law 930, passed by the 84th Congress, the Secretary of Commerce is to set up commercial standards for safety devices that will make a refrigerator door easy to open from the inside. The standards are to be established by August 1957. Fifteen months after that it will become unlawful to ship in interstate commerce any household refrigerator not equipped with a device conforming with them.

Health Protection

A group of pediatricians from more than a dozen States recently established a nonprofit organization, the National Council on Infant and Child Care, Inc., to offer counsel to those who disseminate information concerning health and medical care of infants and children.

In its statement of principles and purpose the Council says that it recognizes the natural interest of the public in medical information and will strive to replace confusing, misleading, or irresponsible information with appropriate, valid material. The Council describes as its functions: to provide pediatric information to medical-science writers; to review lay articles on pediatric subjects before publication, when requested, and afterward when such action seems needed; to consult on planned advertising of products for use in pediatric care and to evaluate advertising already published; to publish appropriate material; and to foster effective medical, industrial, and public relationships for improvement of all phases of infant and child care.

The Council has adopted a set of basic principles to guide manufacturers, advertisers, and writers and editors in presenting material concerned with child health to the public.

Backed financially by a number of industries making nutritional products for children, the Council is also seeking support from a foundation.

Refugee Children

The International Union of Child Welfare has established a special delegation in Vienna to stimulate and coordinate the relief efforts of its member organizations in behalf of Hungarian refugee children in Austria and to collaborate with other international organizations in this work. The program has included the establishment of reception centers for mothers and children, the assumption of maintenance responsibility for 3,000 mothers and their children, the gathering and distribution of supplies, and the launching of a "sponsorship" program, a fund raising campaign based on an appeal for individual financial support for each child. More than 25 membership organizations from as many countries have either already contributed to this work or have announced their intention of doing so. In distributing the contributions it receives in cash or in kind the Union works closely with its Austrian member, *Rettet das Kind*, which is playing a leading role in the relief activities.

The Union is also making efforts through the International Committee of the Red Cross to find ways of getting relief to children inside Hungary and of helping children affected by the recent conflicts in the Middle East.

Adoptions

A father and mother's long-continued failure to visit their children in foster homes, without a satisfactory excuse and under circumstances that indicated a settled purpose to forego all parental rights and responsibilities, constituted abandonment of them, in a ruling of a Surrogate's Court in Brooklyn, N. Y., October 25, 1956. On this ground the court appointed guardians for a brother and sister, 12 and 11 years old. Furthermore, the court held that since New York State law provides that the consent of a parent who has abandoned a child is not necessary for the child's adoption, such consent would not be required for the adoption of these children. Evidence was presented that both children had been living in foster homes since infancy and had seldom been visited by their parents. At the time the petition, brought by two social agencies, for appointment of guardians was heard by the court the boy had last seen his father in 1947 and his mother in 1949; the girl had last seen her mother and father in 1954.

The court pointed out "that the procedure established in this case will serve as a guide to the Department of Welfare of the City of New York to the adoption of hundreds of helpless children who have been abandoned by parents."

Professional

An examination for specialists in social work is being held by the Board of U. S. Civil Service Examiners, Children's Bureau, U. S. Department of Health, Education, and Welfare. No

closing date has been set. Child-welfare, research, juvenile-delinquency, and medical social-work positions in the Children's Bureau will be filled from this examination, as well as medical social-work positions in the Public Health Service and in the Bureau of Public Assistance.

To qualify, applicants must have successfully completed 2 years of graduate study (1 year for research positions) in an accredited school of social work. They must also have had appropriate experience in the field for which they apply. No written test is required. The beginning salaries for these positions range from $6,390 to $8,990 a year.

Applications should be sent directly to the Board of U. S. Civil Service Examiners, Children's Bureau, U. S. Department of Health, Education, and Welfare. Full information regarding the requirements and how to apply is contained in Announcement No. 91 B, which may be obtained at many post offices, or from the U. S. Civil Service Commission, Washington 25, D. C.

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Here and There

Fourteen States and a Territory enacted legislation in 1955 and 1956, adopting the Interstate Compact on Juveniles, recommended by the Council of State Governments. The purposes of the compact are to permit: (1) the supervision by the authorities of one State of juveniles placed on probation or parole by another; (2) the detention and return of juveniles, whether delinquent or not, who have run away across State lines; (3) the cooperative care and treatment of juveniles found delinquent in one State in specialized institutions in another.

. . .

Children in Alaska will soon benefit from the Department of Agriculture's Special Milk Program, which was recently extended to the Territory. This action was taken by the Department after studies carried out by its Alaska Experiment Station showed that milk consumption by school children in Alaska could be materially increased by making milk more readily available at reduced prices. Children eligible to take part in the program include those in schools, nursery schools, settlement houses, summer camps, and other nonprofit child-care institutions. The program will be administered by the Alaska Department of Education.

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The Child Study Association has announced the beginning of a 3-year research project on social science and parent education, sponsored jointly by the Association and the Russell Sage Foundation. The Association has also begun publishing a newsletter entitled "Parent Education Exchange Bulletin," which presents information from many sources on parent-education activities.

IN THE JOURNALS

Accident Prevention

A 3-year community drive to stimulate prevention of accidents among children is described in the *New England Journal of Medicine* for December 27, 1956, by R. Gerald Rice, M. D., George W. Starbuck, M. D., and Robert B. Reed, Ph. D. Initiated by the Massachusetts State Department of Public Health, sponsored by the New Bedford Medical Society and a local hospital, and financed by a private foundation, the program was carried out in four communities known as Greater New Bedford. Physicians, hospitals, schools, public-health nurses, and the police reported accidents among children up to 16 years of age to the program director. The accidents were investigated and analyzed statistically, and the facts publicized.

Among the follow-up steps taken in the community were: creation of a hospital poison-information center, a bicycle-safety program in the schools, a YWCA safety course for teen-age baby-sitters, a parent-teacher project on home accidents, and a program of safety instruction for nurses; and expansion of swimming and boating instruction by municipal-beach authorities and others. Physicians were given safety literature including home-safety check lists.

Unmarried Mothers

One of the first steps toward solving the complex problem of providing help to unmarried mothers is to spread the information that professional help is available, says Nancy B. Johnston in *Social Casework* for December 1956 ("A Few Comments on Unmarried Mothers."). We still do not know how the community can plan so that every unmarried mother may be offered help at an appropriate time and in an acceptable way, the author maintains.

Reporting on a study of 73 mothers of babies born out of wedlock in a tax-supported hospital, she notes that most of the young women knew nothing of resources for help, and nearly all came to the hospital late in pregnancy. Only 6 of the 73 had had any contact with a social agency; only 28 had received prenatal care.

Hospital social workers had little time to establish relationships with the mothers—the average stay after delivery was only 3 days—and 44 of the 73 mothers left the hospital without accepting the casework service offered. However, says the author, from our brief contacts with this group we feel certain that many of them would have welcomed guidance and counsel before the point of crisis arrived if they had known that such help was available.

To Foster Happy Families

Physicians, nurses, and health educators should recognize that routines can be adapted successfully to meet the needs of mothers and babies, says Hazel Corbin in the January 1957 issue of *American Journal of Nursing*. Discussing various types of needs, the author, who is general director of the Maternity Center Association, New York City, maintains that the time is ripe for an interdisciplinary program designed to insure not only physical health for the expectant mother and her child but also achievement of a happy family relationship and warm, secure bonds between parents and children.

BOOK NOTES

DELINQUENCY; the juvenile offender in America today. Herbert A. Bloch and Frank T. Flynn. Random House, New York. 1956. 612 pp. $7.95.

Part 1 of this book by a professor of sociology and a professor of social work discusses the meaning and scope of delinquency. Part 2 analyzes efforts to discover principles that would enable persons who work with delinquents to understand how various conditions lead to delinquent behavior. Part 3 considers treatment agencies—the police, detention facilities, the juvenile court—and methods of treating young offenders who are over juvenile-court age. Part 4 reviews some programs aimed at preventing delinquency.

Two appendices analyze the case histories and treatment of two delinquent boys of very different social backgrounds. One showed signs of considerable improvement at the end of a period of parole supervision; the other was recommitted to a training school after carrying out new crimes during parole supervision.

THE PSYCHOANALYTIC STUDY OF THE CHILD, Vol. XI. Edited by Ruth S. Eissler and others. International Universities Press, New York. 1956. 470 pp. $8.50.

The 19 papers included in this volume are divided into four sections: "Theoretical Contributions," "Normal and Pathological Development," "Clinical Contributions," and "Applied Psychoanalysis."

PHYSIQUE AND DELINQUENCY. Sheldon and Eleanor Glueck. Harper & Bros., New York. 1956. 339 pp. $6.

Based on data collected by the authors on 500 delinquent and 500 nondelinquent boys reported in their "Unraveling Juvenile Delinquency," this book relates the information statistically to the boys' body builds, classified into four types: mesomorphic (bone and muscle physique); endomorphic (soft, round physique); ectomorphic (linear, fragile physique); and balanced. In the light of what they regard as the special needs of boys of each type, the authors offer suggestions for fulfilling these needs in four areas: family life; schooling; use of leisure; and psychotherapy for both delinquents and nondelinquents.

SPEECH DISORDERS; principles and practices of therapy. Mildred Freburg Berry and Jon Eisenson. Appleton-Century-Crofts, Inc., New York. 1956. 573 pp. $6.75.

Aiming to present comprehensive and systematized knowledge of the chief disorders of speech, the author of this textbook explain the physiological and psychological bases of speech and set forth in detail methods of testing and habilitating children with various forms of speech defect. Among the groups of children considered are: stutterers; cerebral-palsied children; children with cleft palate; and children whose speech defect is associated with impaired hearing.

The book is addressed mainly to students beginning major study in the field of speech correction. Current research is referred to throughout for the benefit of advanced students, and the authors express the hope that doctors, nurses, psychologists, and parents of speech-handicapped children will find the book valuable.

A BELIEF IN PEOPLE; a history of family social work. Margaret E. Rich. Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. 1956. 190 pp. $3.50.

This book reviews the development of family service societies in the United States from their early beginnings in the charity-organization movement 75 years ago, through their increased efforts toward improving their skill in serving people—which led to the establishment of schools of social work and the growth of the social casework profession—to their present multipronged concern with the provision of casework service to individuals and families, community education on family life, and leadership in the development of sound social-welfare programs. Throughout, the story is told from the vantage point of the societies' national membership organization, once the National Association of Societies for Organizing Charity, later the Family Welfare Association of America, and now the Family Service Association of America. Several chapters tell of the part played by the Association in meeting the social emergencies of the depression, wartime, and postwar years.

The author, who died a few weeks after completing the manuscript, participated in a professional capacity for nearly 50 years in the movement she describes.

EPILEPTIC SEIZURES; a correlative study of historical, diagnostic, therapeutic, educational, and employment aspects of epilepsy. Edited by John R. Green and Harry F. Steelman. Williams & Wilkins Co., Baltimore. 1956. 165 pp. $5.

Seventeen papers presented at the joint meetings of the Seventh Western Institute on Epilepsy, the Western Society of Electroencephalography, and the Arizona chapter of the American Academy of General Practice are the basis for this symposium on epileptic seizures. Addressed to general practitioners, internists, pediatricians, medical students, educators, employers, and parents, the contents consider the diagnosis and treatment of epileptic seizures and the social, educational, and employment problems involved in rehabilitation of epileptic patients.

OTHER PEOPLE'S CHILDREN. Anna Judge Peters Levy. Ronald Press Co., New York. 1956. 287 pp. $3.75.

The author, a juvenile-court judge for a number of years, describes 11 cases that she considers representative of those that came before the juvenile courts of the country. The cases selected show how complex the situations in such cases are. One arose from a child's resistance to adoption, and others from adult-child sexual relationships, heterosexual and homosexual. Others center around victims of cruel treatment by parent, foster parent, or stepparent.

The author acknowledges the shortcomings and difficulties of juvenile courts, but she considers the future

of these courts promising. She notes as their greatest need an adequate number of probation officers qualified by training, experience, and temperament to perform their difficult task.

Written in popular style, the book calls attention to the need for improvement in court and community services.

PROBLEMS OF FAMILY LIFE AND HOW TO MEET THEM. Edited by Maxwell S. Stewart. Foreword by Ernest Osborne. Harper & Bros., New York. 1956. 227 pp. $3.50.

Composed of a group of popular pamphlets originally published by the Public Affairs Committee, this book includes, among others, chapters on family planning, mixed marriages, working mothers, special problems with children, broken homes. The book is addressed to family members, and "all whose responsibilities bring them in contact with people who are first of all husbands, wives, and parents."

SLOW TO TALK: a guide for teachers and parents of children with delayed language development. Jane Beasley. Bureau of Publications, Teachers College, Columbia University, New York. 1956. 109 pp. $2.75.

Throughout this book the author stresses the emotional climate in which the child with delayed speech can best learn to talk, rather than technical methods of teaching him. The book considers development patterns of childhood in general and notes possible variations in a child who has not learned to talk at 3 to 5 years of age. It reviews research findings on language development, notes current assumptions about how a child learns, and sets up a framework for home and nursery-school efforts to help the child who is slow to talk.

PROBLEMS OF ADOLESCENTS. H. Edelston. Philosophical Library, New York. 1956. 174 pp. $4.75.

This book describes several meetings on sex education conducted by the author for a mixed group of young people 17 and older. The first step was a 45-minute lecture, reproduced in the book, planned as a general survey to stimulate questions, which would be answered at the next meeting. The questions were in writing and anonymous. Most of the book is devoted to the questions taken up at subsequent meetings, and the author's answers.

GUIDES AND REPORTS

RESEARCH EVALUATING A CHILD STUDY PROGRAM. Richard M. Brandt and Hugh V. Perkins. Child Development Publications of the Society for Research in Child Development, Purdue University, Lafayette, Ind. (Monographs of the Society, Vol. 21, Serial No. 62, No. 1, 1956.) 96 pp. $2.75.

Summarizes 10 years' research in evaluating a program in which individual children are studied by their own teachers and the results analyzed by groups of teachers in biweekly meetings.

A STUDY IN NEGRO ADOPTION. David Fanshel. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. Commentary by Alexander J. Allen. 1957. 108 pp. $2.50.

Examines the outcome of applications by 224 Negro and 183 white couples to Pittsburgh's Family and Children's Service for children for adoption. Compares the characteristics of couples who received children with those who withdrew their applications or were rejected by the agency in terms of income, educational background, marital history, age, skin color (among Negroes) and ethnic background (among whites), and source of referral.

THE CHILD AND HIS FAMILY IN DISASTER: a study of the 1953 Vicksburg tornado. Stewart E. Perry, Earle Silber, and Donald A. Bloch. Committee on Disaster Studies, National Academy of Sciences–National Research Council. Pub. 394, Disaster Study No. 5. Washington, D. C. 1956. 62 pp. $1.50.

Reports on a study of the psychological effects on children and their families of a tornado that killed 5 and injured 20 children at a Saturday afternoon motion-picture performance. With the purpose of finding out what helps or hinders recovery from the psychological trauma of disaster, the study concludes with recommendations for parental and school attitudes and policies in a post-disaster period. The study was a joint project of the National Institute of Mental Health and the Committee on Disaster Studies, carried out with the help of the Mississippi State Department of Public Welfare.

MOBILIZING COMMUNITY RESOURCES FOR YOUTH; identification and treatment of maladjusted, delinquent, and gifted children. Paul H. Bowman, Robert F. DeHaan, John K. Kough, and Gordon P. Liddle. Youth Development Series, No. 3. Edited by Robert J. Havighurst. University of Chicago Press. Supplementary Educational Monographs, No. 85. 1956. 138 pp. $2.50.

Describes the third and fourth years' work of a 10-year project to discover symptoms of maladjustment and of special talent in elementary-school children and to give each group special help through counseling.

CHILD WELFARE SUPERVISION IN LOCAL PUBLIC WELFARE AGENCIES. 84 pp. THE INTAKE STUDY IN CHILD WELFARE, third edition. 20 pp. New York State Department of Social Welfare, 112 State Street, Albany, N. Y. 1956. Available without charge from the New York State Department of Social Welfare.

These two publications, financed by Federal child-welfare-services funds, offer guidelines for supervisors of local public child-welfare divisions and their staffs in giving better service to children and their parents. The first replaces an earlier publication, "Guide to Thinking on Supervision in a Rural Public Child Welfare Unit."

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE; a guide to boards, administration, and staffs of child-caring agencies. Compiled by Edith L. Lauer and Henrietta L. Gordon. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. 1955. 32 pp. 75 cents.

Last revised in 1946, this guide outlines the duties of child-caring agencies with regard to the health of children under their care.

READERS' EXCHANGE

REDL: *No ivory tower*

Dr. Redl's call for "practice-geared research" in the field of delinquency should stimulate a greater tie-in between practitioners in various areas of delinquency control and researchers, but I believe he has overemphasized the ivory-tower nature of much criminologic research. ("Research Needs in the Delinquency Field," by Fritz Redl, CHILDREN, January–February 1957.)

In regard to his comments on *Assessment of Treatment Needs* I think he ignores fundamental research which demonstrates that it is possible, through predictive techniques, to improve decisions regarding the various types of correctional action to be taken in specific cases. These techniques can greatly improve clinical as well as judicial practices in assessing specific treatment needs, through the bringing to bear upon the individual case, of the precipitate of experience with hundreds of similar cases.

Under the heading *What is Right With Them?* Dr. Redl discusses the very important topic of yardsticks to measure "*progress, improvement* or partial or total *cure* in a therapeutic situation." In our followup studies Mrs. Glueck and I have emphasized recidivism as the test, although we fully recognize that there are other measures of progress or retrogression. It is true that psychiatry, particularly psychoanalysis, has been notoriously weak in evaluating its efforts. Dr. Redl's call for a more discriminating system of standards of evaluation is therefore justified. In the meantime, however, it must be emphasized that the development of improved standards for measuring progress is dependent largely on the thoroughness of the followup techniques employed.

In this connection, there is no escape from that *Escape Into the IBM Machine* which Dr. Redl deplores, for statistical prediction requires the counting and intercorrelation of factors. The individual case gives the experienced clinician certain insights; but whether these are generally meaningful depends upon the frequency with which traits and characteristics noted in the single case actually occur in the general run of cases, and to know this requires a statistical analysis of uniformities and dissimilarities. I do not mean to imply that the prediction table should replace the ripe judgment of the clinician, judge, or parole administrator in the individual case; the statistical table of experience is not intended to be the master but the servant of the practitioner.

Under the heading, *What Traits?* Dr. Redl refers to the very important need of determining the specific characteristics that "make for a good worker with disturbed children," and he calls for "organized research into the question of trait syndromes and their relationship to specific professional performances." Mrs. Glueck and I have long felt this a fundamental need. In a number of our researches we found that some probation or parole officers achieved a much higher proportion of success with their charges than was attained by others. Investigation indicated that the difference stemmed not so much from professional education as from certain qualities of personality—as though nature had endowed them with what might be called "a therapeutic personality." We have often called for an intensive research into the qualities of such persons in order that effective selective devices might be developed.

It is no detraction from the value of Dr. Redl's ideas to point out that it is far easier to make such suggestions than to design specific research projects to implement them.

Sheldon Glueck
Roscoe Pound Professor of Law, Harvard University

STUDT: *What about content?*

Mrs. Studt's article whets the appetite of those of us who are pondering the problem of preparing social-work students to work in the field of corrections. ("An Experiment in Training Teachers for Corrections," by Elliot Studt, CHILDREN, January–February 1957.) The questions that await answer are those of the *content* of courses in corrections not the courses concerned with programs, but those concerned with methods. What should be taught? What likenesses and differences between casework as now taught in schools of social work and the principles and processes of the correctional field were identified by the project the article describes?

I have long been a proponent of generic courses in casework, and by this, I mean courses in which the constant and characteristic elements of specific casework practices have been carefully identified, analyzed, and then synthesized- without which "generic" becomes a synonym for hodgepodge. However, I have an idea that for a time, at least, corrections will need to be an area of some specialization in practice and in teaching. It seems to me that there are many aspects of work in corrections that are as yet quite unclarified, and for a time we will need to identify it separately from other organized forms of helping in order to analyze it more precisely. For example, there is the question as to whether degree of authority does or does not make for some actual difference in kind; and again the question as to whether the qualities of personality now considered to be most desirable in a social caseworker are the same or different for a caseworker in corrections.

I know Mrs. Studt's article did not pretend to deal with the problems of teaching content. I write this chiefly to express the hope that it will not be long before she will write again and more extensively on this urgent and, as yet, opaque subject.

Helen Harris Perlman
Professor of Social Work, University of Chicago

BOOLE: *The parent's rights*

Miss Boole's article, "The Hospital and Unmarried Mothers," (CHILDREN, November-December 1956) illustrates an approach to unmarried mothers which is essential to good maternity care and to cooperative and coordinated services in and out of a hospital setting.

The individual and legal rights of the natural parent, married or unmarried, who gives a child for adoption calls for further emphasis. There are still extremes in practice and attitude among

professional persons in regard to the desirability of allowing or requiring a mother giving up her child for adoption to see and care for her baby while in the hospital. What the mother does in this respect should in most instances be her own decision. To force either approach stems from a subjective and judgmental attitude on the part of hospital and professional personnel and a disregard of the mother as an individual with legal rights. Unless the mother is unduly disturbed, she is the best judge of what she wants to do and can be helped to express this by an objective, noninvolved professional person, such as a social worker.

It is up to the medical social worker to see that the unmarried mother's rights are respected by all hospital personnel. She also has a responsibility for being informed about the legal aspects of child placement as these affect administrative procedures for discharging a child from the hospital to someone other than his own parents. This information should be passed on to the natural parent, the hospital personnel, and persons outside the hospital to insure protection for everyone involved and reduce last-minute confusion at time of discharge.

The approach to the unmarried mother described by Miss Boole should apply both to private and clinic patients. A lack of financial pressure does not obliterate the mother's other needs for help.

Mary Jean Clark
Senior Social Worker, Chicago Lying-in Hospital, University of Chicago Clinics

NIXON: *Preventive programs*

Many child-guidance clinics now recognize that good clinical service programs should be accompanied by efforts in training of personnel, in development of clinical research, and in prevention of emotional disturbance. In his excellent description of the broad program at the Child Study Center of the Institute of the Pennsylvania Hospital, ("A Child-Guidance Clinic Explores Ways to Prevention," CHILDREN, January-February 1957), Dr. Nixon stressed the center's use of "open house case presentations" which apparently are attended by many community leaders. While he pointed out that careful planning goes into each case presentation he did not make it clear whether this included selection of case material in an orderly, systematic manner (e. g., through developmental phases) which is a discernible trend in many preventive mental-health programs in this country.

I am inclined to be skeptical of any extensive true learning about the unconscious components of personality taking place in such large sessions, and therefore wonder if the Philadelphia group has made any informal or formal inquiries into the value of these programs beyond the increased understanding of the clinic's function and limitations. Finally, I wonder how much detail of child-therapy techniques is presented to these large audiences. Perhaps some followup studies similar to those done by Balzer in New York will be attempted in Philadelphia.

I am very enthusiastic about the center's nursery-school program and about the special child-health conferences described by Dr. Nixon. In my opinion, child-guidance clinics, particularly those in teaching institutions, should stress such programs much more in the training of mental-health personnel, medical students, pediatricians, nurses, teachers, and others. Although these teaching activities are time-consuming they clearly give the personnel of the child-guidance clinic a good opportunity to learn more about behavior and about the contributions of other professional colleagues to mental health.

Dr. Nixon's article reminds us that child-guidance clinics should be concerned with the development of a variety of programs that reach out to persons who work directly with children in various settings. It should focus our attention on the need to develop specific programs, with theories, goals, and evaluative procedures.

R. L. Stubblefield, M. D.
Director, Psychiatric Clinic, University of Colorado Medical Center

An additional challenge

Dr. Nixon's description of the experiments in mental-health education undertaken at the Child Study Center of the Institute of the Pennsylvania Hospital brings to the fore again the question of the content and methods of programs for spreading mental-health principles.

The article describes one kind of educational approach involving case presentations and conferences to provide participants with basic information about the personality growth of children and the bearing on this of family relationships. This approach, as Dr. Nixon pointed out, also challenges the members of the child-guidance team to be able to communicate their knowledge and to identify those basic psychiatric principles which are pertinent to maintenance of mental health.

There is an additional challenge. It is to find ways which will facilitate the translation of such information into specific usefulness on the job. An accumulating body of experience points to the effectiveness of mental-health education carried out in the setting in which it is to be used. This approach is described in the report of the broadly conceived program in St. Louis ("Preventive Mental-Health Services in a Public-Health Setting," by Herbert R. Domke and A. D. Buehmueller, CHILDREN, November - December 1956.) It makes it possible for the members of a psychiatric team not only to impart information, but in turn to learn of the specific problems which other professionals encounter in carrying out their regular jobs.

I am reminded of the experiences of the staff in a well-baby clinic which had a consulting psychiatrist. As members of the staff integrated mental-health concepts into their other equipment for carrying out their ongoing services to parents and children, they found time somehow to discharge the responsibilities their newly broadened perspectives demanded of them. They also began to become concerned about the dearth of contacts with children between the ages of 2 and 6, as they began to see the urgency for following a child through those years. Some administrative alterations became necessary, but they were part of a fanning-out process resulting from mutual acquaintance with problems as education *in situ* proceeded.

Eric E. Welsch, M. D.
Columbia University Medical Center, New York

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SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

EDUCATION FOR NATIONAL SURVIVAL; a handbook on civil defense for schools. Department of Health, Education, and Welfare, Office of Education. 1956. 88 pp. 65 cents.

This handbook contains suggestions to assist school administrators and teachers in planning protective measures for school civil defense. It includes checklists for the administrator, for teachers, and for other school personnel; lists of films and publications; a step-by-step outline for drafting a school civil-defense plan; and a form for reporting on an exercise in school evacuation. The publication was prepared by the Office of Education under a delegation of authority and responsibility by the Federal Civil Defense Administration.

AN IDEA IN ACTION: new teachers for the Nation's children. Department of Labor, Women's Bureau. Pamphlet Two. 1956. 37 pp. 20 cents.

This report describes early results of an effort to combat the teacher shortage by preparing selected mature college graduates for teaching in elementary and secondary schools. More than a hundred colleges and universities offering programs for such preparation are listed, with a statement of minimum qualifications for entrance and a brief description of the program.

FEDERAL FUNDS FOR EDUCATION, 1954–55 and 1955–56. Clayton D. Hutchins, Albert R. Munse, and Edna D. Booher. Department of Health, Education, and Welfare, Office of Education. Bulletin 1956 No. 5. 163 pp. 60 cents.

Ninety-nine education programs in which the Federal Government participates are described in this bulletin, the thirteenth in a series issued biennially since the school year 1933–34 by the Office of Education. The Federal assistance reported is in the form of commodities, funds, or services for activities in public or private educational institutions or agencies. Excluded are programs of in-service training for Federal employees whole on duty if the training is provided elsewhere than in educational institutions and is open only to Federal employees.

TRAINING UNDER THE MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S PROGRAMS, 1954. Children's Bureau Statistical Series No. 34. 1956. 20 pp. Single copies available from the Children's Bureau without charge.

This publication is the Children's Bureau's first statistical report on training provided under the State-Federal maternal and child health and crippled children's programs. Covering the fiscal year ended June 30, 1954, it includes detailed figures on the number of professional personnel who received some training and the Federal, State, and local expenditures involved, under the regular grant-in-aid programs; and some information on the special training projects of regional or national significance which are financed through grants from a reserve Federal fund.

THE CHILD WHO IS MENTALLY RETARDED. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1956. CB Folder 43. 23 pp. 10 cents.

Some general guidelines for parents of mentally retarded children are suggested in this small pamphlet along with sources of further help.

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Library opportunities are no longer the exclusive privilege of town dwellers, as is attested by these Kentucky mountain children checking out books from a bookmobile. About 100 bookmobiles are being operated in Kentucky, the result of a statewide drive for funds and books. About half their books are for children.

Encouraging the establishment of regional libraries and the operation of bookmobiles are two ways in which States are helping localities to get books into the hands of rural people. These efforts are now being stepped up through a 5-year Federal-aid program for the extension of library service to rural areas, authorized by Congress in June 1956. For this Congress appropriated $2,050,000 of the $7,500,000 authorized for the fiscal year now ending. By the end of March, 38 States had submitted plans for participation.

A native of Nova Scotia, George F. Davidson first entered the field of social welfare in British Columbia, where he worked in both Provincial and voluntary agencies. He was executive secretary of the Canadian Welfare Council, a voluntary organization with headquarters in Ottawa, Ont., before becoming head of the Canadian Government's newly established welfare division in 1944. He is currently the president of the International Conference of Social Work.

In addition to carrying out her duties for the D. C. Department of Public Health, Loura L. Dittmann teaches nursery-school teachers at the University of Virginia's Northern University Center in Arlington, Va., and meets regularly with a group of parents of retarded children in Montgomery County, Md. Mrs. Dittmann received her training at the Merrill-Palmer School in Detroit and has worked in numerous nursery schools as well as at a hospital where she provided counseling and home-training aid to the parents of preschool blind children.

With a master's degree in sociology from Columbia University and in social work from Boston University, Ralph L. Kolodny is a member of the joint committee of the psychiatric social work and groupwork sections of the National Association of Social Workers, which is currently planning conferences on the use of the group method by social workers in clinical settings. In addition to working as research supervisor in the program he describes, he teaches social groupwork at Boston University.

For a large portion of the 21 years she has been on the staff of the Children's Bureau Maud Morlock has focused her main attention on two efforts: getting help to unmarried mothers through community agencies and the extension and improvement of homemaker services to families needing them. Trained in social work at the University of Chicago, the New York School of Social Work, and the London School of Economics, Miss Morlock has also had extensive casework and administrative experience in voluntary agencies. She taught child welfare at Western Reserve University for 15 years.

Anne Leatherman has been in the Texas Department of Public Welfare for the last 15 years, serving for 3 years as a public-assistance worker before being assigned as a county child-welfare worker. Leaves of absence for training at the Tulane University School of Social Work and at the New York School of Social Work, Columbia University, resulted in the department's using her in increasingly responsible supervisory capacities. Before her present assignment a year ago she was the department's State foster-family care consultant.

◀ *the authors*

Twelve years of administering a "baby bonus" program prompts a Canadian welfare official to look at . . .

CANADA'S FAMILY ALLOWANCES IN RETROSPECT

GEORGE F. DAVIDSON, Ph. D.
Deputy Minister of Welfare, Department of National Health and Welfare, Ottawa, Canada

CANADA'S POPULATION in the month of June 1956 officially passed the 16-million mark. In that same month Canada's family-allowance program, closing its eleventh full year of operation, reached out across the country to provide benefits for 5,425,127 of the nation's children—slightly more than one out of every three persons in the country.

If the parents of these under-sixteens—the mothers and fathers of the 2,279,099 families in which they live—are added to the total, it is safe to say that, except for taxes and postal services, no governmental action affects so regularly or so directly the lives of so many Canadians. More than half the population of Canada—counting adults and children—benefit directly each month. The entire population helps to foot the bill through payment of the taxes which underwrite Canada's most expensive social welfare undertaking.

What is the background and history of this program which adds at the present time $400 million a year to the Canadian tax bill—roughly $25 annually for every man, woman, and child in the country? What do Canadians think of this king-sized social experiment, unique in the North American Continent? Is it possible now, after more than 11 years of experience in its operation to come to any conclusions as to its demographic, social, or economic effects on the Canadian people?

Canada's "baby bonus" program—to call it by its unofficial name applied originally as an epithet of contempt by its opponents but now become almost respectable through popular usage—was itself a "war baby." Nobody quite knows who its parents really were, fiscal experts, economists, postwar planners, or practical politicians. Most evidence points to the probability that the parents of Canada's family-allowance program were among the most responsible and conservative elements in Ottawa, none other than the highly respected officers of the Bank of Canada and the Finance Department itself.

The Family Allowances Act provides that the Government of Canada shall pay a monthly allowance out of its general tax revenues to the mother of every child under 16 born in Canada, or who has been living in Canada for a period of one year. These allowances amount to $5 for each such child under 6; $6 for each child 6 to 10; $7 for each child 10 to 13; and $8 for 13- to 16-year-olds. No means test is applied. No "insurance" contribution is required. The allowances are not subject to the income tax. However, since they are intended to replace in part those allowances for children made by granting an income-tax exemption, the exemption for each child under the income-tax law has been considerably reduced since the beginning of the program. At present only $150 a year can be deducted from taxable income for each child eligible for a family allowance, as

compared to the $400 exemption allowed for an ineligible child.

The Objectives

The social objective of the program is to compensate at least in part for the inequity resulting from the principle of equal pay rates for equal productivity in the industrial wage system. This system allows for little consideration of differences in the social and economic needs of the wage earners' families. A wage packet that may be ample for the single man or a married childless couple may be woefully insufficient for a large family.

Children under such circumstances are economic liabilities. This may not have been true to the same extent in an earlier day in a rural-style economy when children could help on the farm and when school-attendance laws did not keep them out of the labor market. But in the industrial society of today, with laws providing for compulsory school attendance to the age of 16 in most Canadian jurisdictions, the financial burden of parenthood can be heavy. Family allowances seek to ease and redistribute this burden to some extent by offering, from the resources of the nation as a whole, financial assistance to parents who have taken on the responsibility of raising the future generation of its citizens.

While this social objective was undoubtedly in the minds of those responsible for the inauguration of family allowances in Canada, it was not the primary consideration at the time. The prime objective was an economic one. Family allowances were looked upon as a way of maintaining consumer purchasing power in the uncertain postwar demobilization period. It is perhaps not surprising that 12 years later, in 1957, when the North American economy is being subjected to severe inflationary pressures, the antideflationary objective of the family-allowance program seems a little outdated. Whatever the main purpose originally, the social-welfare objectives are now the ones which predominate. In any discussion of family allowances in Canada the program tends to be judged by what it has accomplished as a social rather than as a general economic measure.

The Public's Attitude

Public approval of the family-allowance program is today so universal that it is difficult to credit the bitter opposition which the legislation originally aroused. Here are a few samples of the criticism expressed in 1944 and 1945 by one of the program's most outspoken opponents:

"The act was probably the most precipitate and indefensible piece of legislation which a civilized government has ever ventured to pass in wartime. . . . To any careful student of social welfare, it was a most disgusting exhibition of political chicanery and economic ignorance parading in the pious vestments of concern for the common man. . . . The Family Allowances Act will cause endless antagonism in Canada on religious grounds, however lamentable such an antagonism would be. . . . In a country which is relatively homogeneous, racially and religiously, family allowances might constitute no threat to national unity, but in a country like Canada which is characterized by marked differentials in the birthrate of the constituent ethnic groups, such an act will mean the end of national unity and spread bitter antagonism throughout the Dominion. . . . 'The world,' said Thomas Carlyle, 'is made up of so many millions of people, mostly fools,' but for an all-time high in folly and stupidity, the award should go to Anglo-Canadians if, in their sad muddleheadedness, they take this measure lying down!" [1]

These are harsh words directed in 1945 toward a measure which now, according to latest public-opinion polls, commands the positive support of no less than 90 percent of all Canadians. It would be difficult to find more impressive evidence of the steadily growing public acceptance of any social measure than that shown in table I.

Table I. GROWTH IN PUBLIC FAVOR OF FAMILY ALLOWANCE

	1943 percent	1947 percent	1948 percent	1950 percent	1955 percent
FAMILY ALLOWANCE:					
Is a good thing	49	71	75	84	90
Not a good thing	42	16	13	9	6
Undecided	9	10	12	7	4
Total	100	100	100	100	100

Gallup Poll of Canada, *Toronto Star*, December 3, 1955.

While the figures point to a division of opinion in Canada prior to the inception of the family-allowance program, they also clearly show that soon after its inauguration the program established itself solidly in the public mind as a good thing, and that public approval of it has grown overwhelmingly stronger with each passing year. In the light of

this evidence, the 1945 arguments against family allowances forecasting religious wars and racial cleavages seem now about as anachronistic as the antideflationary arguments in favor of them.

Current Criticism

It should not be assumed, however, from these evidences of public support that there is no criticism today of family allowances in Canada. Criticism in 1957 takes a different line. Strong opponents — and there are still some scattered throughout the country—point with alarm to the inflationary effect of the allowances, to their disproportionately high cost, to their shrinking value as the cost-of-living index rises. Much more could be accomplished, these critics argue, at less than half the cost, by a sensible program which gives an adequate amount of assistance to those in need instead of spreading payments indiscriminately over all families, most of whom are not in need.

This argument overlooks entirely the fact that families in the more comfortable income brackets are receiving now, through family allowances, no more, and in some instances less, than the amounts they were formerly allowed to exempt from their income taxes for their children; and that it would only divide the population once again into the "haves" and the "have nots" if these families were to be removed from family-allowance rolls and be compensated therefor through higher income-tax exemptions for their children.

Another kind of criticism of the present family-allowance program comes from persons who think that Canada should have more, not less, of them. It is argued, with growing frequency, that the amounts now paid are wholly inadequate and should be substantially increased. It is pointed out in this connection that inflation has eaten away much of the purchasing power of family-allowance payments and that today the still current 1945 rates—$5, $6, $7, or $8 monthly depending on the age of the child—have been reduced in value to little more than half their original purchasing power.

The latter argument is incontestable in view of the abundant evidence of increased living costs since the end of World War II. Nevertheless, it is not so easy to face up to the financial implications of any change in the amounts of benefits now being paid. With the program having well over 5 million child beneficiaries each month, simple arithmetic shows that even a modest increase of $1 per child per month would mean an increase in cost of over $60 million a year, and this on top of an already recurring annual increment of $13 million due to mere population growth. Obviously any government is going to think twice before it accepts the logic of an argument, however compelling, when the inevitable result will be such a substantial increase in continuing expenditures, adding further fuel to the flames of inflation.

Beginning September 1, increased benefits will go to approximately 3½ million of the nearly 5½ million children now included in the Canadian family-allowance program. The boost is allowed for in the budget for the next fiscal year presented to the Canadian Parliament in March. It will come about through a change in rates which replaces the four rates described in the accompanying article with two.

The new rates will be: $6 a month for children under 10, and $8 a month for children between 10 and 16. Thus children under 6, who now qualify for only $5 each a month by way of family allowance, will qualify for $6, the same as their older brothers and sisters who have not yet reached their tenth birthday; and children between 10 and 13, now bringing the family only $7 via the allowance, will bring in $8, the same as the 13- to 16-year-olds.

The Results

From July 1945 to date, close to $31½ billion has been paid through the family-allowance program to assist Canadian parents in raising their children. Some impressive claims have been made for its accomplishments in a variety of fields—demographic, social, and economic. What do we *know* about the results that have flowed from this program?

No simple catalogue of answers can be given to this question. So many influences have been at work in postwar Canadian society that to single out particular trends attributable exclusively to the family-allowance program is well-nigh impossible.

It is true, of course, as United States Senator Richard Neuberger has written in his article, "Canada's Social Security System for Children,"[2] that "soon after the enactment of the Family Allowances Statute, infant mortality dropped, and there was an

increased demand for pediatricians." However, it is impossible to establish that these results stemmed from family allowances and not from other factors operating in the postwar demobilization period.

It is true, too, that milk consumption rose in the aftermath of World War II by 39 million pounds a month, and annual production of children's shoes from 9 to 14 million pairs. How much of this was due to family allowances? No one really knows. Some skeptics have pointed out that sales of beer and other alcoholic beverages also increased sharply in the same period.

How can the exact role of family allowances in the many and diverse postwar trends be impartially determined? The simple and honest answer is that this cannot be done.

Let us take, for example, the question—hotly debated in 1945—of the effect of family allowances on the birth rate. What do we find? By 1945, the year in which family allowances were first paid, the Canadian birthrate had partially recovered from its depression low point of 20 per 1,000 of the population and stood at 23.9 per 1,000. In the following year, the first full year of family allowances, the birthrate jumped an unprecedented 13 percent to 27 per 1,000, rose even higher to a record 28.7 in 1947 and has never since dropped below the 1946 rate.

It is tempting to give family allowances some of the credit for this startling and sustained increase. Before doing so, however, one should pause to reflect upon the fact that in our neighboring country, the United States of America, where family allowances do not exist, the upturn in the birthrate since 1945 has been even greater and just as fully sustained. In the United States the 1945 birthrate of 19.5 per 1,000 shot up almost 20 percent to 23.3 in 1946, rose even higher to a record 25.8 in 1947, and has never since dropped back below its 1946 level. This striking parallel between the postwar experiences of the United States and Canada seems to indicate that the sensational postwar recovery in the North American birthrate is the result of a complex of factors, including demobilization and sustained economic prosperity, and that the inauguration of family allowances in Canada merely coincided with this continent-wide trend.

Similarly tempting, but equally dubious, conclusions might be drawn in regard to the relationship between family allowances and infant and maternal mortality rates. In both of these important indices of child and maternal welfare, Canada has experienced an encouraging downward trend in the postwar years. The infant mortality rate, which stood at 51 per 1,000 live births in 1945, steadily dropped in each successive year to 31 in 1955; while the maternal death rate dropped even more sharply from 2.3 per 1,000 live births in 1945 to 0.8 in 1955. Once again, however, comparison with the postwar experience of other countries like our own shows the danger of jumping to conclusions on the role of family allowances in this trend. Again, all that can be said is that the trend coincides with, rather than stems from, the inauguration of the family-allowance program.

There seems to be solider ground for considering the effects of family allowances on school attendance. The act specifies that payments cannot be made if a child does not attend school as required by Provincial law. Through administrative arrangements with Provincial and local educational authorities, family allowances have thus become the most effective truant officer the Canadian school system has even known. From every Provincial educational authority have come similar reports:

"The problem of poor attendance in the Province was almost wholly eliminated by family-allowance payments."

"We feel that your Division has been very helpful in raising the percentage attendance in our schools."

"You are the most effective attendance officers the Province has ever had."

These and numerous other statements from school authorities provide impressive evidence of the beneficial influence exercised by family allowances on school attendance.

Numerous attempts have been made during the past 11 years to assess the effect of family allowances on the individual family budget. Family allowances, according to the legislation, must be used exclusively for the "maintenance, care, training, education, and advancement of the child." For what purposes have the family-allowance moneys actually been used? This too is difficult to determine with any accuracy.

Family-allowance dollars, once the monthly check has been cashed, cannot be distinguished in any way from any other dollars which the housewife or the wage earner has to spend. For this reason, it is next to impossible to tell definitely from the general expenditure patterns of the families taken as a whole in what ways family-allowance moneys are spent. However, surveys and questionnaires have indicated that parents use their family-allowance moneys primarily for clothing, food, savings, and medical care in that order. They also indicate that a significant

percentage of the families try to set aside the allowance money from other income for something directly related to the children's needs.

Practically all parents when questioned acknowledge an awareness of the fact that family-allowance moneys are intended for their children's welfare and advancement and maintain that their efforts are centered, directly or indirectly, on the achievement of this objective. A good deal of what they say can perhaps be discounted on the grounds that parents under such circumstances will give the answers which they think the questioner wants. Nevertheless, one must still conclude, unless completely cynical, that family allowances, being paid to mothers whenever possible, are being placed in the hands of the very persons who are most likely to make the best use of them in the interests of the nation's children.

What They Have Not Done

However difficult it may be to determine the positive results of family allowances, it is not so hard to specify those predictions which family allowances have *not* realized. None of the dire consequences prophesied by the program's early opponents have come to pass. Canada has *not* been split asunder on either racial or religious grounds. The mental defectives and the improvident have *not* multiplied at the expense of the saner, more responsible elements in the population. There has been no burgeoning of large families; in fact the number of very large families has not kept pace proportionately with the increase in the total child population. More small families, more middle-sized families, but proportionately fewer large-sized families have followed the inauguration of the program.

Nor has there been a sudden upsurge of the French-Catholic birthrate at the expense of the Anglo-Protestant—a prospect that was greatly feared in certain Anglo-Protestant sections of the country. In fact, there are indications that the Anglo-Protestant birthrate has risen more sharply in the postwar decade than the French-Catholic birthrate. The latter, however, was already considerably the higher.

In the beginning many social workers, even those who favored family allowances in principle, feared that the cost of the program would make it exceedingly difficult to obtain funds for other social-welfare purposes.

However, the experience of the past 12 years has shown this fear to be groundless. Old-age security for all persons over 70, old-age assistance for needy persons aged 65 to 69, disability allowances, unemployment assistance, extensions and improvements in blindness allowances and unemployment insurance have all been achieved at the Federal level of government since the family-allowance program was inaugurated 11 years ago.

Table II. GENERAL AVERAGE INDEX NUMBER OF WAGE RATES 1945-54 (rate in 1949 = 100)

Year	Index number
1945	69.3
1946	75.9
1947	84.9
1948	95.7
1949	100.0
1950	105.5
1951	119.1
1952	127.7
1953	133.6
1954	137.9

Economics and Research Branch, Canada Department of Labour.

The National Health Grants program, begun in 1948, and the Federal Government's current proposals to the Provinces in regard to hospital insurance provide further evidence that rather than slowing down advances in other health and welfare fields, the family-allowance program may actually have triggered off a whole series of new social initiatives on the part of the Federal Government.

Certainly there have been more rapid advances in the field of social security since the passage of the Family Allowances Act of 1944 than in all the earlier years of Canada's history. The precise role of family allowances in this development is not easy to determine, but at least it can be said with confidence that family allowances have not proved to be a financial obstacle to progress in other social fields.

Nor have the family-allowance payments had the unfavorable effect on work incentives and on wage rates forecast by some of the prophets of gloom a decade ago. Wage rates have gone up steadily in Canada since 1945 when family allowances first were introduced. (See table II.) A similar rise has occurred in the United States.

Figures on the size of Canada's labor force, on national productivity, on the national income and gross national product also explode allegations that the effect of family allowances would be to diminish

Table III. COMPARISON OF DISTRIBUTION OF TOTAL FEDERAL TAX COLLECTIONS AND FAMILY-ALLOWANCE PAYMENTS BY REGIONS, 1953 54.

	Total Federal tax collections*		Total family allowances	
	In millions of dollars	As percent of total	Payments (in millions)	As percent of total
Atlantic	154. 4	3. 5	45. 5	13. 0
Quebec	1, 299. 2	30. 0	111. 5	31. 9
Ontario	2, 146. 6	49. 4	104. 5	29. 9
Prairies	416. 7	9. 6	62. 2	17. 8
British Columbia	323. 9	7. 5	25. 9	7. 4
Total	4, 340. 8	100. 0	349. 6	100. 0

*Report of the Department of National Revenue for the fiscal year ended March 31, 1954.

work incentives on the part of the Canadian wage earner.

Redistribution of Income

Canada's family-allowance program is definitely effective in redistributing income. This redistribution takes place not only between the upper- and lower-income families, but also between the economically favored and the economically disinherited areas of the country, as table III shows.

Maritime and Prairie Provinces have long been the less prosperous regions of Canada. The Maritimes contribute only 3.5 percent of all Federal Government tax revenues, while receiving 13 percent of total family-allowance payments. The Prairie Provinces contribute only 9.6 percent of all tax dollars collected by the national Government, while they receive 17.8 percent of total family-allowance payments. British Columbia and French-Catholic Quebec balance out fairly evenly, with British Columbia taking slightly less and Quebec slightly more than their proportionate shares of family-allowance payments in relation to the tax revenues they produce.

Ontario is the one real "loser" in the sense that it contributes a disproportionately high percentage of the Federal tax revenues in comparison to the percentage of family-allowance payments it receives. But Ontario is in all respects the prosperous industrial heart of Canada—the center of most of the nation's greatest industrial and commercial establishments. Ontario's industry has been the chief beneficiary of Canada's protective tariffs and in many other respects the favored child of the Canadian confederation.

One of the chief challenges to statesmanship in Canada is to find some means of balancing the scales of economic and social justice between the "have not" and the more prosperous Provinces. In addition to what it does to assist the average Canadian family, the family-allowance program contributes perhaps even more significantly than is presently realized to the achievement of this wider national objective.

[1] Silcox, C. E.: The revenge of the cradles. Toronto: Ryerson Press, 1945.

[2] Neuberger, Richard: Canada's social security system for children. The Reporter, April 27, 1954.

Those who are engaged in some act or operation which from its nature is likely to cause injury to others, unless special precautions are taken, must take such precautions as skill, foresight, and experience suggest as being necessary. The possession or use of articles which are dangerous by nature, such as dangerous chemicals or explosives, imposes on the person possessing or using them the duty to take the highest possible degree of care. Where children, for example, are likely to be attracted to those dangerous things, either the latter should be put out of reach, or the child must be warned, and it must be known that he has fully appreciated the warning. It is not too much to say that where atomic energy is concerned we are all like children.

Professor Kathleen Lonsdale, D. Sc., F. R. S., University College, London, 1954.

In the District of Columbia a diagnostic and evaluation clinic provides . . .

HOME TRAINING FOR RETARDED CHILDREN

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WHEN the District of Columbia Department of Public Health established a clinic for retarded children as a special project in its Bureau of Maternal and Child Health, it determined on two important features: geographic location outside of a hospital and the provision of continuing service to the family after diagnosis.

The clinic's professional staff includes a full-time psychiatric-medical social worker and a pediatrician, a clinical psychologist, a psychiatrist, and a child-development specialist, all on a part-time basis. Also participating is a part-time pediatric consultant public-health nurse. This staff functions initially as a diagnostic team, incorporating the findings of other specialists in building a picture of a child. For the diagnosis the clinic utilizes as needed the resources of the Bureau's Crippled Children's Services. These include neurology, electroencephalography, physical medicine, occupational therapy, ophthalmology, hearing and speech evaluation, and public-health nursing. The staff members of these services often participate in the treatment plan.

As part of its continuing service the clinic provides, on a selective basis, social casework services, short-term psychotherapy, home training, and referral to other community agencies.

The home-training program is worked out by the child-development specialist, who focuses on helping parents with the practical problems of daily living with a mentally handicapped child. The specialist participates with the team in planning the overall treatment program by giving reports on the child's behavior. Her reports are based on observations usually made in the clinic's playroom when the child is playing by himself, though occasionally they are supplemented by observations of the child's behavior with other children there or in his own home with his parents, his brothers or sisters, or adults other than his parents.

The child-development worker learns something of the ways in which the child relates to people and the anxiety or ease with which he accepts separation from his parents. She also notes how he handles his body and how he uses his sensory equipment, thus getting an idea of the picture he has of himself and of whether or not there might be a defect in his sensory endowment. She learns something of the degree of his social adjustment by observing his play habits, his ability to communicate, how he handles his own clothing, how he deals with aggression, and whether or not he has any understanding of the rights of others. She reports further information about the child stemming either from her own observations or from parent's reports bearing on such matters as feeding, toileting, and patterns of expressing affection.

At its evaluation conference the team sets up goals for helping the child and his family which may require a continuing relationship of the child-development worker with the family. This may mean planning with the family to help the child achieve specific skills within his area of competence such as

learning to pull off his shoes and socks or to feed himself.

The following cases portray the variety of activities included in a home-training program.

A Severely Retarded Boy

The mother of John, aged 2, came to the clinic in an effort to avoid having to "institutionalize" her son. He had already been studied carefully at the Johns Hopkins Hospital and was under private neurologic care for seizures. These, nevertheless, continued from 3 to 12 times a day in the form of mild loss of contact with his surroundings.

The family was referred by a private social agency, to which the parents had gone originally to discuss placement. As time went on, several factors had changed their purpose: a slight improvement in John who began to control his body movements; pressure from his grandparents who were shocked at the idea of "putting him away"; hearing other parents talk before and after committing a child; and finally, a visit to the institution under consideration.

Since the parents were now asking help in training, the clinic accepted the referral.

Medically, John was summarized as a child with convulsive disorder which showed up in a markedly abnormal electroencephalogram. When he was a year old a psychologist at Johns Hopkins University found him to be functioning at a 12-week level in most areas, with a stronger ability—about 16 weeks—in motor areas.

The home-training program consistent with such a diagnosis included:

1. Advice on ways of handling this heavy (35 pound) boy at home.

2. Study of feeding techniques.

3. Assistance to the mother in making a more accurate evaluation of the child's potentialities. The mother had shown an understandable tendency to exaggerate progress, having pitted herself against medical advice to put the child in an institution.

The child-development worker carried out her services through visits to the home.

On the first visit the mother was feeding the child liquid food in a low "baby-tenda" from which lifting was difficult. He sucked the food in very fast, throwing his head back to swallow it without stopping to taste it. At the end of the meal the mother tried to demonstrate how her son handled a cup and a spoon, but he had lost interest and accomplished nothing. During this visit the worker stressed the values of the following:

1. A more convenient kind of seating arrangement (higher).

2. A more civilized rate of speed.

3. Self-feeding opportunities at the beginning of the meal.

4. The use of other food textures.

The worker later discussed these recommendations with the pediatrician, particularly those regarding food textures. The pediatrician suggested solid foods such as banana, cooked carrot, hard-boiled eggs, and zwieback, in rather large pieces which John could handle himself.

Revisiting the home a month later the worker noted some change. John brought his head toward the spoon. Also, the mother had slowed down the feeding process—a difficult achievement for her since the child's dispatch in tucking away a large plate of pureed food was one of the few real satisfactions in her day.

On subsequent visits the worker discussed toilet training with the mother, suggesting that complete continence was an unrealistic goal and recommending cutting down on the amount of time the child was left on the toilet seat. She also recommended certain bathing techniques.

At each visit the mother made some comment either for or against institutional placement, as though she were arguing out the problem with herself in the worker's presence. Eventually, she formulated the idea that she would "place" John when he learned to walk, which she thought would occur at about 3 or 4 years of age. Since this plan made it desirable to evaluate the child's rate of growth, the worker made an appointment for him with the clinic's psychologist.

The psychologist found John to be a child who "does little in coming to grips with materials." She reported: "He is able, at 2 years and 2 months of age, to succeed in some items at the 2-month level, and had scattered successes through 5 months. Motor development is superior to other areas, and on the report of the mother he scored at 8 months largely because of this. He did not transfer objects from one hand to the other; he did not turn at the sound of a voice or the ringing of a bell. Left to his own

The child development specialist (right) on a home training visit watches a mother as she helps her mentally retarded child to learn to feed himself. The bright little boy on the extreme right is the retarded child's brother.

devices on the floor, he made active cooing and laughing sounds, scratched his clothing, and sucked his fingers."

These findings were interpreted to the mother by the clinic's medical director in the light of what could be projected for John in the future. By a comparison of this test with the previous one the parents were given some idea of the rate at which development was occurring. They finally had to face the question of whether or not John would ever be able to walk.

Meanwhile the mother continued to try to improve feeding techniques and to stimulate John to move about on the floor. At the end of 8 months John had made limited but nevertheless real progress. He showed less messiness in swallowing; he spilt less milk and reached for the cup to bring it to his mouth, although he still needed a guiding hand. He could carry a filled spoon to his mouth for 3 or 4 successive trips. He would drop the spoon, however, when it reached his mouth. The mother had become more relaxed with the boy and seemed to feel that since her efforts had produced some results she did not need to pad the picture to make the clinic understand her drive to keep him at home.

At one point the mother purchased a walker in order to get John to move about a bit by himself. However, the walker turned out to be too short for him and possibly too light. The worker suggested that a consultation with other mothers having similar equipment problems might be helpful. John's mother as well as several other mothers of heavy, non-walking, convulsive children, enthusiastically accepted this idea and decided to meet together regularly to discuss their problems.

At these group meetings with the child development worker the mothers talked about walkers, where to buy rubber pants big enough for such children, what kind of a bed other than a crib could be safe for a child who might convulse at night, and how to build outdoor play yards, stronger and bigger than playpens, which would not require lifting the child over an edge. They talked about potty chairs versus toilets, how to build outdoor swings, where to buy clothes which did not look too old for children who still seemed like babies. The clinic's psychiatric social worker sat in on some of these meetings. From time to time the mothers discussed such problems as how to deal with typical mannerisitic behavior—studying the hands, rocking, weird noises—and how differently they felt about such behavior when it occurred at home or in public.

Toward the end of the series of discussions John's mother told the child-development worker that she was pregnant. Thereafter, her feelings toward her son began to change and she could say that sometimes she would look at him and "just be tired of him," though she would hasten to add that this was not all the time. At this point she began to consider institutional placement with an entirely different point of view. Because of this change the child-development worker referred her to the social worker for help in thinking toward this step. When she eventually committed the child she was invited to return to the clinic at any time she wished. She did not return, and the one time she phoned she announced that she felt all right about the commitment.

The experience of working under supervision to train her child apparently helped this mother to see his limitations more clearly and helped to free her to go ahead with her own life and family planning.

A Mongoloid Child

Not all of the children seen at the clinic need such elementary instruction in self-care as did John. For example, there was Sammy, a frail, spindly, 5-year-old Mongoloid boy. The team's study showed him to be a child who had achieved the basic self-help accomplishments but who badly needed social opportunities.

Sammy was referred to the clinic by a public-health nurse, who had known his family through her work at school where she saw his three older brothers. The mother, a tired, tense, thin woman, tended to two extremes in her way of looking at her youngest child. Sometimes she expressed the fear that he would stop growing completely and be just as he was for the rest of his life. At others she would reveal the hope that when he was able to go to school he would catch up with other children completely.

Sammy's mother had done a remarkably good job in exploiting her son's capacities for training to the fullest, and yet she seemed unable to relate his actual progress to her dreams or fears about him. Although she had watched in her three other children the orderly progression of development from one small understanding or skill to the next, she was unable to expect any such developmental pattern in Sammy.

Both of Sammy's parents were foreign born. The father came from England, where he had been a valet and chauffeur, and the mother from Finland. Now the father, unable to find other work, was making a meager income driving a cab.

Sammy's mother indicated that he was toilet trained if she assumed some responsibility for catching him, that he played with toys with interest, that he was a slow eater and would not touch food with his hands, that he tried to dress himself but could not button, and that he could not undress himself. He had been a slow child from the beginning and had not walked until he was 3. He still slept in a crib and was prone to rock.

The pediatrician's examination revealed that Sammy had very bad tonsils, which contributed not only to his failure to gain weight but also to poor resistance to infection. An eye examination showed that his retardation was not aggravated by poor vision. The psychologist described Sammy as a "fragile-looking, socially responsive child who enjoys playing with materials." This specialist reported: "At age 5 he tested at about 18 months, somewhat penalized by his lack of speech. However, the social quotient as determined by a Vineland scale was higher, around 21 months."

Sammy's relatively high social quotient was testimony to the mother's achievements in training. The clinic team, therefore, outlined the home-training program in this case as: (1) providing support for the mother in her training efforts; (2) helping her to see Sammy's potentials for further learning in specific terms; (3) examining the child's eating habits for the possibility of teaching him to pick up things with his hands; (4) encouraging the parents to follow through on the physician's recommendation for a tonsillectomy.

On her first home visit the worker watched Sammy eat, neatly, two bowls of vegetable soup and an 8-ounce jar of baby food consisting of fruit and farina. He refused to pick up crackers in his fingers and the mother complained that he also would not pick up candy, bread, toast, or cake. In discussing this idiosyncrasy with his mother the worker learned that Sammy liked to eat puddings, bread in food, fruit, meat, potatoes, eggs, bacon, two cups of milk a day, fruit juice, broccoli, ice cream. After some explanation of the adequacy of Sammy's present diet and a reference to other mothers' troubles in keeping their children from candy and cake, the worker suggested to the mother that perhaps she should settle back and enjoy the excellent and neat manner with which Sammy could handle utensils.

Sammy's mother showed that she had a fine working understanding not only of the ways to teach Sammy, but also of how to select specific goals. Said she: "I wait for him to give me the things to work on." When he showed an interest in learning how to get upstairs, helping him with this became the most important activity of her day. When he became interested in taking off his shoes, she allowed him all the time he needed to unlace his orthopedic shoes, remove them, and place his socks inside them

Two children in the playroom of the District of Columbia's clinic for the mentally retarded learn social skills from the child development specialist while their mothers are being interviewed by other members of the clinic's staff.

before he went to nap. Through her patient efforts she revealed that on a day to-day basis she accepted her child's limitations.

During the worker's visits this mother also revealed an ambivalent attitude toward Sammy's condition by saying in one breath that she could not wait for him to go to kindergarten, and in the next, that she was afraid of having him be with big, normal children who would shove him around and knock him down.

During the next few months Sammy's tonsils were removed, thus freeing the boy from a tremendous drain of colds and infection. At a home visit after the operation the worker saw him eat three bowls of cereal with lots of milk and a bowl of applesauce for breakfast.

At this time, the family was having an unusually difficult time financially. Since the mother was continuing to buy a special vitamin-A milk for Sammy, though she could hardly stretch her food money to cover school lunches for the older children, the worker suggested that she come in for a conference with the Bureau's nutritionist, who could counsel her on how to choose less expensive, though nourishing, foods. She readily accepted this suggestion.

Sammy's lack of association with other children increasingly worried his mother. When he was refused admission to a nursery school for physically handicapped children, the worker suggested that the mother organize a small play group in her own living room to provide him with a not-too-demanding social opportunity and, hopefully, to lead him eventually into other living rooms. The mother commandeered three children almost at once, but after the first meeting complained that Sammy just watched while the others came in and broke his toys. The worker suggested that she cut back the size of the group to include just one other child, the youngest of the three original visitors, a little boy, aged 3.

At her next visit the worker helped the mother to see how to divide the morning into periods of free play, a more quiet, organized activity, and solitary-but-adjacent doings. The worker also showed her how to read a story to young children, taught her some simple circle and finger games and discussed with her techniques of handling a small group.

Sammy now meets with two other children twice a week. So far the group has not left his living room. However, both Sammy and the young visitors show evidences of social growth and some understanding of the rights of others.

Here, while the skills of team members have contributed to a more comfortable situation in the family, the mother's own devotion and patience have been primary factors in the retarded child's growth.

A Potentially Normal Child

Another child with whom the child-development specialist has worked might be considered normal potentially. In this case the worker strove more to bring about a change in the parents' attitude than to teach skills. The child, Joe, aged 5, was referred to the clinic for psychological testing after he had failed to adjust in his second try at attending kindergarten. Other specialists had noted that the parents were smothering Joe with overprotection and had recommended foster-home placement. At the clinic Joe underwent a complete diagnostic study, with his family's consent.

This boy's outstanding symptom was his difficulty in separating from his parents. At the clinic he could not accept their being in an office adjacent to the playroom with the door open. His parents reported the following:

He fed himself but was picky, disliking vegetables, fruits, and meats. He was afraid of the dark. He was very slow in dressing himself, could button but not tie, and was apt to get things on backwards. He made a lot of noise, talking mostly to himself in gibberish. His behavior was "flighty" and they could sometimes control him only with a strap. He was beginning to stop sucking his thumb, but had many temper tantrums during which he would hit his head and rock.

These parents said that they had felt "life was not worth living" after they had discovered that Joe was retarded. They were not clear about who had told them the child was retarded.

Psychological testing at the clinic scored this 5½-year-old boy with a mental age of not quite 4, but the test pattern indicated higher potentials. He showed unevenness and variability in functioning. Some of his behavior was negativistic while his responses showed immaturity in some developmental areas such as fine coordination. The psychologist's recommendation included a "positive experience with an accepting adult and an opportunity to be with other children in a structured situation."

Physical examination showed no medical problems or abnormalities.

The child-development worker's visit to the home revealed that there Joe was in even less control of himself than he was in the clinic. He acted as though he resented his mother's attempt to talk to

the visitor and exhibited an extremely short attention span and very little common sense. The worker also noted that many of his play materials were fragile or too complicated for him. His puzzles, for example, would have been hard for an 8-year-old. Most of all he liked to get behind his bed and beat upon a drum.

During this visit the mother seemed somewhat less tense than she had in the clinic.

The staff program for this family included work with both the mother and the child. Coincidentally, the clinic at this time had decided to observe a group of children for a few weeks to see if they were ready for kindergarten. Joe became part of this group. The plan was for the psychiatric social worker to hold both individual and group conferences with the mothers of these children while the child-development worker worked with the children individually and in groups. The sessions were carried on in the clinic.

At the first of these an attempt was made to help Joe let his mother out of his sight for a very short interval. This was given up when it proved too distressing for him. On his second visit Joe arrived at the clinic in tears lest a separation occur. His mother assured him that it would not but in an aside to the child-development worker said that she would leave the playroom surreptitiously. This gave the worker an opportunity to discuss the desirability of a straightforward approach to the child, without cajoling or lying. No separation was attempted at this visit.

A few weeks later Joe seemed ready to play with another child but when he did so his behavior became so wild that he had to be removed from the room and kept away until he could pull himself together. The child-development worker's discussion with the mother at this time centered on the importance of setting limits for the boy and giving him a clear-cut notion of what was expected of him.

Six group sessions a week followed during which the prekindergarten program included activities organized by the teacher as well as some modified free play. Joe was able to participate in this program with special assistance from the teacher. Eventually he seemed ready for a regular kindergarten.

During the summer the family moved to a new neighborhood. In response to the clinic's interest in knowing how Joe adjusted to kindergarten, the family made an appointment to visit the clinic after school had begun.

At this visit Joe showed signs of having grown considerably in self-control, in his ability to face another person and talk directly to him, and in the quality of his play life and handling of materials. His mother reported that he no longer beat drums constantly. After Joe and his mother made two more trips to the clinic a conference with both mother and father was held to suspend the clinic's relationship with the family for a while. Both parents remarked that a miracle had occurred. Nevertheless, they were unable to see the cause and effect of their slightly modified ways in handling their child. They were continuing a pattern of overprotection in such ways as accompanying Joe to and from school, although none of the other children in the class had this kind of supervision. It seemed impossible to help these parents understand that Joe would need increasing independence.

The parents left the clinic's service with the understanding that the staff would recheck by telephone during the winter and review Joe's situation the following spring, when next steps might be formulated. Meanwhile, one can only hope that in the absence of more fundamental changes, the introduction into the social world which entering school has meant for Joe can assist him in continuing the healthy growth already observed.

An Experimental Program

These three cases point up the wide variation in types of help from which parents and children can profit through a clinic for the mentally retarded, involving problems ranging from those presented by the grossly damaged child who requires total care to those of the child without any apparent organic defect who requires help in becoming a functioning member of the community. So little has been done in the past in helping parents with such children, particularly those of preschool age, that the techniques for doing so are still largely in an experimental stage. The need for help, too, is so vast that it is doubtful whether an evaluation clinic could ever furnish all the direct service required. What a clinic can do at this point, perhaps, is to learn through such an experimental program what the methods and techniques are that are required and so build up a body of knowledge and skill which can be passed on, on a consultation basis, to the staffs of the referring public-health and social agencies, so that they can more adequately help families with such problems as they meet them in their work.

The isolation of a crippled child from his normal peers breaks down through . . .

THERAPEUTIC GROUP WORK WITH HANDICAPPED CHILDREN

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MEDICINE, casework, and psychiatry have all made substantial contributions to the rehabilitation of physically handicapped children. They have not, however, dealt directly with the special problems of social adaptation that confront the physically handicapped child. Already sensitive to his handicap, such a child finds that other children of his own age show limited tolerance, at best, for his inability to participate fully in play.

Some handicapped children are able to surmount this difficulty and to win a place in the social life of their neighborhood. Even among them, however, what seems like a fairly good adjustment may sometimes actually represent over-compensation, an unwillingness to accept realistic limitations. On the other hand, many handicapped children, having their feelings of inadequacy reinforced by experiences of rejection by their contemporaries, tend to retreat from social contacts. Such children need special assistance to help them participate with security in the social activities of their peers.

To meet these needs the Boston Children's Service Association gradually evolved the program now carried on by its department of neighborhood clubs. Referrals of physically handicapped children for groupwork service come to the department from medical social workers, specialized agencies for the handicapped, and parents. Usually the department does not place these children in groups made up of others who are similarly handicapped, though in a few instances involving children needing special protection it forms groups of children with one type of handicap. Its normal procedure is to form a club around each handicapped child, the other members being drawn from physically normal children in the child's neighborhood. This gives the handicapped child an opportunity to participate in a kind of group experience that would ordinarily be inaccessible to him. This approach to group composition derives from the theory that association with normal children, under trained, professional leadership can provide many handicapped children with a corrective emotional experience. The goal is the integration of the handicapped child, insofar as his capacities allow, into the normal life of his peers.

The policy of not including more than one handicapped child to a group should perhaps be further examined. It is based on the theory that having more than one such child in a group can introduce intense rivalries which other members may not be able to accept.

Of the approximately 30 groups conducted by the department each year, about half come into being as a result of the referral of physically handicapped children. The department has formed groups around preadolescents and adolescents of both sexes, with a wide variety of handicaps—orthopedic, cardiac, urinary, auditory and others. They have included homebound children as well as those who are able to get about. Primary responsibility for the

formation and leadership of groups is carried by the department's full-time staff of professional groupworkers, although some groups are led by second-year groupwork students or part-time paid leaders who are graduate students in related fields.

Most groups begin by meeting in the handicapped child's home. As soon as it is feasible, however, meeting-places are rotated so that the homes of other members are used as well. If a youth-serving agency exists in the neighborhood, meetings may be held there, occasionally at first and later regularly. The choice of meeting place and the process of movement to other meeting places depend upon a combination of factors: medical restrictions on the handicapped child's movement, his emotional readiness to leave his own home for meetings, the physical suitability of the home for meetings, the availability of neighborhood resources and the age of group members.

Limits on activities used in the group are set by the referred child's handicap. Within these limits the kinds of activities the leader suggests are determined by the interests and capabilities of the handicapped child and the other members. In a group formed around a hemophiliac confined to a wheelchair, for example, programs might include: informal dramatics, sedentary games of a type which allow the safe expression of aggression, crafts with blunt tools, and active games involving the use of the upper part of the body. The program developed is related primarily to the child's needs as a person, rather than to his handicap per se.

Preparing the Child

The groupworkers focus their efforts, primarily, on the group process itself. We are interested in structuring program and guiding interaction in such a way that the handicapped child as well as the other members of the group will find an increasing amount of satisfaction and mutual acceptance as they meet, play and work together. We learned early in our experience, however, that the use which the children make of the group and of their relations with one another depends largely upon how carefully the worker has prepared each member and his parents for the experience. The process and procedure of group formation, therefore, assume an importance which is no less vital than the actual process of working with the group after it is formed. If we do not first recognize and try to handle some of the anxieties of those most directly concerned with the group, including parents and family members as well as the handicapped child and other club members, we can vitiate our rehabilitative plans.

Any strikingly new experience, whatever the pleasures it seems to promise, can seem threatening to the individual. If a handicapped child is to be able to look forward to and enjoy a new experience he must know what to expect. His fears and those of his parents must be allayed.

Both the referring agency and the department take part in the process of preparing the child for a club. If the referring agency is a hospital social-service unit, the medical social worker may begin the process. She introduces the idea of a club to the child and to his mother, pointing out the opportunities a group offers for activities and association with others, and explaining, in general fashion, the group-formation procedures employed by the department. If the child and his parents express an interest in the club she gets in touch with our agency about them.

The referring agency's relationship with the handicapped child and his mother is of crucial importance throughout the referral period. If referral is carried out in perfunctory fashion, confusion and hostility are likely to result. Since formation of the group may take some time, and delay may be upsetting, the security provided by a continuing relationship with the referring worker can be of the utmost importance.

After referral, one of the department's group leaders, or his supervisor, makes a series of visits to the child's home. If possible, both parents and the child are seen at the first visit.

During these early pregroup interviews the groupworker begins the procedure which he follows in all his ensuing relationships with the parents and the child—leaving the initiative in decision making up to them, whenever possible. While he stresses the helpfulness and enjoyment a club experience can bring to the child he does not press for acceptance of the service. He presents it to the mother as a possible aid in her efforts with the child and as a process to which she can contribute some of her own skills and knowledge.

The groupworker attempts to reduce the child's anxiety over participating in a club by relating the experience to something with which he is already familiar. He encourages the child to talk about his interests and the activities he has engaged in when in the hospital or at home alone, explaining to him how he can use these interests and experience in a group.

Although the worker keeps his own questions to

a minimum, he answers the mother's and the child's questions about the club as directly and as fully as possible. He does not belittle their expressed fears, some of which may have a realistic basis. A mother of a child whose condition is aggravated by respiratory infection may be anxious about the possibility of children coming into meetings with colds. In such an instance, the worker explains that adjustments in club procedures can be made so that the child's health will not be endangered, such as an agreement that no one will attend a meeting when he has a cold. Many handicapped children ask the question: "Suppose nobody wants to join?" Aware of the feeling underlying such a question, the worker points out concrete ways in which members have been brought into other similar clubs.

The worker takes up certain other difficult subjects quite directly, without waiting to be asked. He makes it clear to the parent and child that the other club members may come from different backgrounds than they and that the department's policy is to disregard ethnic, religious, and racial origins in forming groups. This can have beneficial effects. The worker's attitudes toward others who are "different" may help the handicapped child to sense the worker's acceptance of his own "difference."

Parental Anxieties

Few parents of the handicapped children categorically reject the idea of a club. Most of them realize the help which guided group association can offer their youngsters. However, because of the emotional pressures to which they have been subjected by their children's illnesses, they display varying degrees of ambivalence when presented with the possibility of such group association. Even the mother who has herself initiated contact with the department shows some ambivalence through various forms of resistance.

Some mothers openly resist the idea of sharing their child's care with an outsider. Some who do not show resistance at first later attempt to control the leader and to dominate the group. A few expect too much, asking to be relieved of their child's care for long periods of time.

Parents always hesitate at the thought of placing a severely handicapped child in regular contact with other children. The mother may be afraid that the child's membership in a club will mean that he will have to compete with other children, to his own and perhaps to her embarrassment. Some mothers have attempted to circumvent this problem by suggesting

Leaning slightly against the table gives this handicapped child enough support to enable her to play ping-pong. The leader of her club, sponsored by the Boston Children's Service Association, encourages her to engage in activities that both she and the normal members of the group can enjoy.

as club members other children who also suffer some handicaps. Some are afraid that the club membership will expose their handicapped children to "aggressive" children. On the other hand some parents of handicapped but ambulatory children, denying their child's need for special help, put pressure on the child to join "regular" groups, such as the Boy Scouts.

While there are some instances where resistance completely blocks the formation of a group, usually the initial resistance on the part of parents is not so profound as to make further work impossible. Ordinarily, their desire to have their child lead a less constricted life enables them to accept the service, despite their fears. They may continue to show anxiety through their behavior in relation to the group, but generally, the groupworker is able to handle any difficulty by accepting their fears and hostilities and showing his interest in them as individuals.

However, some parental fears may remain strong despite the worker's understanding attitude. While a mother may seem to accept the idea of the club by permitting its formation, she and her child may be so bound to each other emotionally that they fear the separation entailed by the meetings or become upset when they are asked to carry responsibility. As a result, the child's attendance becomes

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sporadic. When this occurs the leader does not press either the parent or child but gives their anxiety a chance to subside. He also tries to offer some substitute gratification to the mother, such as increased attention, to make up for her partial loss of the child.

While alert to parental resistances and anxieties, the worker is careful not to lose sight of parental strengths. He encourages the mothers, and, if possible, the fathers to use their interests and skills in helping him to plan for and work with their child and his group, wherever this can be done naturally and in line with group needs.

Group Formation

The process of forming a group around a physically handicapped child may be carried out in several different ways. In every case, the worker first asks the referred child and his mother if they know of neighborhood children who might be interested in joining the club. This not only helps them to make a direct contribution to the alleviation of their own problems, but it may eventually bring together some children whom the child knows and with whom he wants to associate, so reducing his anxiety. If either the mother or child have suggestions for members the worker asks them to describe what these children are like, helping them to evaluate them in relation to their suitability for the group.

The general criteria he uses in attempting to weigh the suitability of a suggested member are: 1) The member should be about the same age as the referred child; 2) he should be able to accept a limited and sometimes sedentary type of program; 3) he must be able to control his impulsiveness; 4) he should not be deeply afraid that the handicapped child's condition is contagious; 5) he should not have displayed an excessively pitying attitude toward the handicapped child in previous contacts; 6) he should not have been consistently in conflict with the handicapped child in the past; 7) there should be some likelihood of his being enthusiastic about the idea of a club as something he himself might enjoy.

If any of the children described by the mother or child do not seem suitable for membership according to these criteria, the worker helps the mother and child to understand why they should not be asked to join.

The children's age often raises problems. Many ambulatory handicapped youngsters wish to include in the group children younger than themselves because they feel more comfortable with them. Explaining the advantages of associating with children of his own age, the groupworker also points out that younger children might feel ill at ease in the group and assures the handicapped child that he can continue to associate with them for free play. On the other hand, the worker also points out that any youngster who joins the group must be able to tolerate a restricted kind of program. This is a sine qua non of membership. A member who is easily frustrated by limitations in activity can disrupt the group and upset the handicapped child.

If the children suggested seem to be likely candidates for club membership the mother is asked to get in touch with their parents about the proposed plans. If she does not wish to do so herself the groupworker undertakes this task. In any event, the worker eventually visits the homes of all of the prospective members.

In some cases neither the mother nor the child knows anyone to propose as members. The worker then suggests that the mother visit the neighborhood school in order to enlist the help of the principal and teachers. Some mothers respond to this idea negatively, and the worker looks for other means of securing members, visiting the school himself or other neighborhood insitutions. When a mother is willing to make school contacts the worker prepares her for her interviews with the school's staff. After someone at the school has talked with suggested children and advised their parents of the department's plan, the worker visits their homes.

In visiting the homes of prospective members, the worker explains the kinds of program activities the proposed group can carry out and what these have to offer in the way of enjoyment, but also points out the limitations that will have to be imposed on the group. He stresses the potential value of the group to *all* members. He also attempts to answer the prospective members' questions, especially those relating to the handicapped child and the nature of his handicap, carefully avoiding the creation of undue anxiety in so doing.

During this first visit the worker attempts to determine the prospective member's suitability for the group. Except when a suggested child is clearly unsuitable for membership he is allowed to join the group if he indicates a desire to do so. While this policy sometimes leads to difficulties, a rigid screening system for membership would be impossible to operate. The use of diagnostic testing in order to evaluate suitability for membership, for example, would give rise to many complications. Even

though parents were to permit such testing, which is unlikely, the procedure would lead to serious problems arising from the exclusion of some of the children tested. It might also inhibit the establishment of a warm "natural" climate in the group. Moreover, the selection of members according to narrowly specific criteria is often made unfeasible by the limitations of the peer population in the neighborhood.

A club formed around a physically handicapped child usually contains from five to eight members. The smallness of the membership is dictated, in part, by the fact that meetings, in many cases, must be held in homes—in kitchens, basements, and bedrooms. It also derives in part from the fact that for some severely handicapped and isolated children, the experience of being exposed to relationships with more than a few new children can be overwhelming. The basic reason for keeping the clubs small, however, is to give the leader opportunity to work effectively with the members.

The Sense of Adequacy

The agency has certain general objectives as well as specific aims in its work with every club. A primary goal in working with a child whose role and status among his peers have been radically altered by illness or accident is to help him to recover a sense of his own worth. The approach is to help the child develop social and play skills which will enable him to take on status-giving roles in interaction with his peers. This is not an easy process since it is always complicated by previously existing emotional problems, either in the child or in members of his family.

Many methods are available to the worker attempting to restore a child's sense of adequacy. Individual workers use different adaptations of them at different times. The process as a whole needs to be studied more intensively before all of the nuances of technique can be identified. Four general steps are, however, clearly necessary:

1. Accepting the handicapped child's dependency and behavior.

2. Helping other members to react less resentfully to his dependency by giving them as much individual attention as possible.

3. Starting with activities which are well within his ability and for which he may have been especially prepared by the leader.

4. Later, gently challenging his tendency to cling to the familiar, through exposing him to carefully planned activities which are not beyond him but which do call upon him to extend himself.

These techniques were an important part of the worker's approach in the case of Sally, aged 11, a polio patient. In reality, they were not separate from other aspects of her approach to the girl or her stepmother or to the problem of group composition, though they will be discussed separately here.

Sally was paralyzed by polio when she was 13. When the group was formed a year later, her prognosis for walking was poor. She and an older sister were children of their father's first marriage. Their young stepmother was strict with both girls but tried to rouse Sally from her inertia.

In the hospital Sally had been difficult to work with and showed little desire to get better. When she returned home the family was unable to accept her poor prognosis and seemed to deny the implications of her illness. Since her shoulders were too weak to support crutches, she got about very little, and remained in bed most of each day.

A cousin and three other girls from the same street, all of them older and more sophisticated, visited her often at first. Upon referral from the hospital a groupworker from the agency initially worked with this "fun" club, although she had misgivings as to its value for Sally. When three of the girls lost interest, the worker set about forming a club with girls who were closer to Sally's level of maturity, from among those Sally had known in school prior to her illness. In this group the aspect of the groupworker's efforts aimed directly at Sally's feelings of inadequacy had to do with program activity.

As Sally had been skillful at handicrafts even before her illness the worker focused the group's attention on this type of activity. Fortunately, the other members also had an interest in handicraft. At first the groupworker visited Sally frequently in order to give her individual training in one craft, copper enameling. As a consequence Sally became very dependent on the groupworker. This development was counterbalanced in the girl by a rise in her self-esteem as she became able to impart her knowledge of copper enameling to the others. She seemed very pleased at meetings when members asked for her help. The group had to depend a good deal on the groupworker at this time, for copper enameling requires a baking kiln which the leader must tend. Sally seemed quite able to share the groupworker's attention with others, perhaps because her skill in the craft enabled her to function more independently than they, thus bringing her a sense of status as well as satisfaction.

Undoubtedly, the others felt some hostility toward Sally because of her superior ability in the enamel work. They did not openly express this, however, perhaps because it was mitigated by their own interest in the work. Moreover, the leader was careful to introduce some other activities for which Sally had not had special preparation, thus making it unnecessary for other members to lag behind her in achievement and challenging her to mobilize herself for something new. She responded well to the challenge and received recognition from the other members in the process. All of these activities made it necessary for Sally to get out of bed and to sit at the table with the others.

While the groupworker allowed Sally to become dependent, she did not encourage her to remain dependent by expecting her to give something back in the way of affection or finished products. Rather, she gave her time and attention to Sally in a manner which stimulated the girl to act more independently in expanding her creative abilities, not in isolation, but in the company of friends.

Sally returned to the hospital for a prolonged period of observation and retraining after 6 months in the group. Nurses who knew her previously have commented on the change in her behavior. Instead of being inert from despair, she has been active in helping the other two girls in her room. Her use of occupational therapy has improved and she seems to enjoy new activities. She has developed a close relationship with a teen-age boy patient and visits him frequently. Generally, she seems now to be participating in her own treatment.

These changes could hardly be attributed solely to the club experience. The medical social workers at the hospital have undoubtedly had a great deal to do with it, as have some changes in Sally's circumstances. She is less sick than she was before. Her stepmother seems to be more accepting of her handicap. Her medical prognosis is better, giving her a chance eventually to walk. But in addition to these factors, the groupworker's approach in the club experience played a part in bringing about the girl's improved outlook and behavior. Through this Sally was helped to develop some of the social and play skills which enable her to use the changes in her situation advantageously.

Other Members' Needs

In every club formed by the agency the worker attends not only to the needs and interests of the handicapped child but also to those of the healthy members of the group. This is true not only in programing for a group but also in planning for its termination.

One worker discovered during the second year of a group's existence that the needs of the handicapped child were beginning to conflict with some of those of the other members. He was having to control program and relationships rather tightly and to use activities focused primarily on the handicapped child's needs. Therefore, for the sake of all the members he planned for the transfer of the club to a regular groupwork agency.

The club centered around Pete, an extremely bright, 10-year-old boy suffering from muscular dystrophy. A previous group formed around him had not worked out well because of lack of interest on the part of its members. The new group, formed at the termination of the first, seemed to bring pleasure to all its members during its first year.

In the second year, however, certain problems arose. The members were physically far more active than they had been earlier. Also, they had become surfeited with the kind of activities they had previously engaged in and even Pete was bored. There was a marked increase in physical horseplay—dangerous for Pete. At one meeting one of the boys started to wrestle with him. It was obvious to the worker that if such incidents were to continue, the experience would reinforce the boy's feelings of inadequacy. Moreover, one of the boys had indicated his impatience by suggesting, at three different meetings, programs which were utterly beyond Pete's capabilities.

Eventually the worker decided to alter procedures in order to enable Pete to have a satisfying experience and to permit the total group to continue to function as a club. While he had been allowing the group to determine its own program insofar as possible, he now attempted to develop program primarily on the basis of Pete's leisure-time interests. For the next 6 months the worker conceived the ideas for the majority of programs, allowing the group members to have a say only in minor ways. Fortunately, they enjoyed the activities the leader devised and Pete was able to participate completely in the social interplay. Among these activities were discussions on adventures in science, simple experiments, and the construction of telegraph and radio equipment.

While recognizing the benefits of this approach for Pete, the worker noted that some of the needs of other members were being slighted. Although the boys attended the meetings regularly with ap-

parent satisfaction, some of them were not being helped in a way in which they might have been in a less controlled group. For example, two of the boys had many problems around authority with which the worker, in the position of a controlling figure, was unable to help them as much as he might have otherwise.

At the end of the group's second year, the worker came to the conclusion that the normal boys had gained as much as they could from the protective group experience the department offered, and that Pete was also ready for experience with a regular groupwork agency. The boy had been anxious to go away to camp for the summer, had not used withdrawal as a defense in his second years' experience with the group, and had exhibited a strong drive for new experiences.

The worker, therefore, made plans to transfer the club to a nearby neighborhood house where another professional worker was assigned as group leader. Even in this new setting the members still have to control themselves in the original group because of Pete's condition. However, their affiliation with the house gives them an opportunity, while continuing in the club, to join other groups in which they may be under less restraint and in which their need for self-expression can be more directly met.

Sooner or later groups must break up. The leader attempts to make this separation by talking with the handicapped child and the rest of the club, at least several months in advance, about termination of his work with them and by dealing with the feelings which arise; by attempting to transfer members, as individuals, or as a group, to a neighborhood center; and by followup contacts with the handicapped child after termination.

Implications of the Experience

Definitive information on methods of rehabilitating physically handicapped children is badly needed. The material just presented clarifies some of the factors that must be taken into account in making a groupwork contribution to the rehabilitative process. However, the knowledge it imparts is necessarily partial and, in some respects, subject to revision on the basis of further experience. The groupworkers in our department of neighborhood clubs have learned a great deal in their practice, but many of their findings must be stated tentatively.

We can, however, make a few definite statements on the basis of this work, all of which point up the importance of planning individually for each child. We have found that:

A group experience with normal children is desirable for many handicapped children. Not all such group experiences, however, are helpful to them. One does not necessarily reduce the problems that a handicapped child has in relating to his normal peers by simply exposing him to peer relationships in a group under the guidance of an interested adult. While one child can be helped by such a procedure, another may be placed under too much stress.

If groupworkers focusing on rehabilitation wish to increase the likelihood of a handicapped child's being helped by a group experience with normal children, they must carefully plan the child's introduction or reintroduction into the social life of his associates. Wherever possible, they must try to bring the handicapped child into the kind of a club in which the structure and activities of the group are related to his emotional and physical needs. They must provide him with a leader who is trained to understand the feelings of handicapped children and their parents in regard to social relationships and who has some awareness of the possible effects of relationships with handicapped children upon the feelings of their healthy peers.

These principles, while presenting great difficulties for any large-scale program, point the direction for helping handicapped children to find physical and emotional security in group experience with their normal peers.

It is always later than we think when a child is brought into court.
Anna Judge Peters Levy, formerly Judge, Juvenile Court, Parish of New Orleans.

HOMEMAKER SERVICES— MAJOR DEFENSE FOR CHILDREN

MAUD MORLOCK

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WHEN THE IDEA of homemaker service emerged in the 1920's, it was seen largely as a way to keep children in their own homes during the temporary hospitalization of the mother or her absence from the home for other reasons. Sending a competent woman into the home to carry on in the mother's absence was regarded by the originators of the idea as far better for children, parents, and agency, than foster care.

Since the 1920's the provision of this kind of service has grown slowly and steadily, but not nearly so rapidly as many people would wish.

Eighty-nine localities in 31 States, the District of Columbia, and Puerto Rico now have some homemaker service available. The service is offered under a variety of auspices by 103 voluntary welfare or health agencies and 25 public agencies. Twenty-two of the latter are local public-welfare agencies. Five States also provide some homemaker service on a case-by-case basis. Probably no community has sufficient homemaker service to meet all its need.

Over the years the concept of how homemakers can help in strengthening services for children has also grown as welfare and health agencies have experienced their value. Today homemakers operating under the supervision of social caseworkers help families and children during the temporary illness of the mother whether or not she is away from the home. They may be put in a home for a long and indefinite stay, as in instances when a mother has entered a tuberculosis sanitorium or a mental hospital. In such instances the homemaker may come into the home before the mother's departure so that the two can learn to know each other and so make the transition easier for the children; and she may remain in the home after the mother's return, thus assuring a sounder period of convalescence.

Homemakers are also being used to keep mothers with mental illness from having to take full responsibility for their families too soon after return home from a hospital. They also help out when a mother is too incapacitated by chronic illness to take full responsibility in the home; or when a mother with several small children needs to devote the major part of her time to a critically ill child and therefore cannot carry out her responsibilities to her other children.

Homemakers help out at times of death, too. When a mother dies, they make it possible for the father to keep the home together so that he can arrive at a plan for his children without undue haste, and with the considered help of the agency's caseworker. Even though he eventually decides that placement is necessary the use of a homemaker gives the agency time to know the children well enough to select suitable homes for them. Many a homemaker with the help of the caseworker has paved the way for the children to accept foster care more easily than they would have been able to under the precipitate placement that would have been necessary without her.

Homemakers are also helping in certain situations where children need protection from the inadequacies of their own parents. The caseworker often finds real strength and warm relationships in families about whom the agency has received complaints of neglect. Usually the parents want to be good parents and to care for their children properly, but

their own immaturity and past experiences have equipped them badly for providing the kind of care the community expects parents to give children. In such families, the children and the parents need the strong supportive help of a caseworker as well as a homemaker. Both can help the parents learn how to give care more adequately to their children and fulfill their own responsibility.

Homemakers also care for children in foster homes when the foster mothers are temporarily ill.

A recent development and one in which there has not been much experience involves the employment of homemakers on a 24-hour basis to meet emergencies arising from sudden illness or crises involving the police. If homemaker service is available, children can be saved from sudden removal from their own homes, perhaps in the middle of the night.

Agencies have become increasingly aware of the need for flexibility in determining how long a homemaker may stay in a family and consequently are exhibiting a growing tendency toward less rigidity about this. This is especially true in respect to families broken by death. For the most part agencies today are not as hesitant as they once were about continuing homemaker service indefinitely in such cases—even for a number of years. They regard such a plan as sound as long as the needs of the children and the surviving parent are being met and there are strengths in the relationships. In some instances, the homemaker may have entered the picture during the terminal illness of the mother and stayed on after the mother's death at the request of the father and the agency. The father and the children often find strength and security in staying together in their own home.

Who Is Involved

In a good homemaking service the caseworker, the homemaker, and the parents can comprise a team working together in the children's behalf. And casework is the cornerstone of the service.

When this is understood the frequently encountered confusion of homemaker service with "maid service" disappears. Inability to pay is not a criterion for eligibility to the service in most agencies. The basic criterion is the family's need for help with problems antedating or growing out of the present difficulty, including assistance in the care of children and in housekeeping. This means the need for the presence within the family of a person who is not only a good housekeeper but also a warm, understanding personality who can look after the children with an awareness of relationships—a person who is in many respects like a "foster mother" serving from within the child's own home.

The importance of casework in a homemaker service comes from the need for counseling on the part of a parent struggling to keep his home together under the emotional strain of circumstances threatening to break it; from the agency's need for assurance that the homemaker will be the best one for the children; and from the need on the part of all applicants for homemaker service—whether eligible for the service or not—of some sort of considered discussion of the problem which brought them to the point of application.

Thus the caseworker contributes in a variety of ways, depending on the particular circumstances, to the family's ability to carry on, and to the experience and skill of the homemaker. At the point of initial application she helps the parent or parents to understand what a homemaker can and cannot do and to consider whether homemaker service is the best plan for meeting their own and their children's needs. Since illness, death, and handicapping conditions are often accompanied by economic, social, and emotional problems many families using homemaker service want continuing consultation with the caseworker.

The caseworker also plays a key role in selecting the homemaker best suited to a particular family, in her training and in her supervision. She uses her casework skill to broaden the homemaker's general understanding of how to get along with children and adults and to help her adjust to a particular family.

The woman who actually works in the home is usually called a "homemaker," but she might be thought of as a "visiting foster mother," a "friendly neighbor," or a "home help"—a term used originally in Great Britain and now adopted to some extent internationally. But whatever her designation, typically she is the kind of person who lends a helping hand in her own neighborhood when some family is in trouble. She likes people and gets along with them, showing appreciation for their strengths and weaknesses. She may be a college graduate or have only a few years of formal schooling. She may be a middle-aged person or comparatively young. She may have raised her own family successfully and now wants some work to supplement her income. She may be a single woman attracted to homemaker service by the idea of helping people in trouble and of working with a social

or health agency. She may be a housewife who has never been employed, or she may have been a teacher or a nurse, or have come from some other occupation.

In those agencies providing organized homemaker services two selection processes are involved—selecting a group of women to become a regular part of the agency's homemaker staff; and selecting the particular homemaker to meet a particular family's needs. Through the employment interview the caseworker tries to learn whether the prospective homemaker can enter into the life of another family without becoming too emotionally involved in its affairs; whether she is patient and tolerant with people and wise enough to know when a change in the family's pattern of living is indicated. The caseworker helps the homemaker to see her work in relation to the agency employing her and be able to work as a member of the team. In some agencies this team includes a home economist who helps in the training of homemakers and may give consultation on home management.

For the social worker the process of recruiting a prospective homemaker is similar to the process of finding a foster mother; and the process of nurturing the ability of each to carry out her task is essentially the same. This nurture may be carried on through group meetings within the agency or in individual contacts between caseworker and homemaker or both. Because group meetings are so difficult to arrange in rural areas, the agencies supplying homemaker service to such areas may have to rely on individual interviews in helping homemakers grow in their understanding of children and parents.

The Problem

While homemaker service has grown in extent and concept over the years, its spread has been slow in relation to need.

Social workers throughout the country tell about children who have been placed in foster homes or institutions because something happens to the mother and no one is available to keep the home together while the father is at work.

An institution executive to whom I talked recently told me that from 10 to 25 percent of the children for whom application to his institution is being made might remain in their own homes if funds were available to employ a homemaker to care for them. He also estimated that 25 percent of the children actually in institutions in the State could be in their own homes if such a service were available. The same could undoubtedly be said in many places not only about children in institutions but also about children in foster-family care.

A homemaker (right) from a county welfare department in North Carolina helps a mother who is crippled from polio give her baby a bath. In North Carolina the State uses Federal funds for child-welfare services to help county welfare departments in operating homemaker services.

One of the major problems in health and welfare is how to get homemaker service to those who need it—children as well as the chronically ill and the aged—wherever they are. Obstacles to doing this are many and varied, particularly in the small towns and rural areas. Distances in some States are great and transportation difficult. Homes are isolated and far from any center of population, making it necessary for homemakers to stay in the home overnight. This presents the problem of providing sleeping space and equipment for their comfort and privacy. It also adds to the difficulty of recruiting women to be homemakers since many prefer to return to their own homes at night.

But in addition to distance, topography, and space there are obstacles growing out of attitudes of people responsible for health and welfare programs. Many of these know of homemaker service only through what they have read. Practically all the literature about the use of homemakers deals with programs in cities and makes no attempt to suggest how these might be adapted to smaller communities or more sparsely settled areas. From this a director of public welfare, a child-welfare worker, or a public-health nurse in a rural county too often concludes that a homemaker service is not suited to the people,

agency, or community he is serving, that it is too complicated and time consuming to undertake.

This reaction is expressed in several ways. Some say the agency already has too many things to do and should not undertake anything new; others, that since the foster-care needs of children in the county are only partially met, nothing new should be attempted. Shortages in staff, limited funds, lack of coverage of counties with child-welfare services, problems in administration are all reasons given for not sponsoring homemaker service. Some agency directors say that any use of homemakers would require more skill, time, and effort than the agency can give. Others maintain that finding and training women for the service or keeping them busy once the service is offered presents insurmountable difficulties. Some say it is too costly.

Actually, however, helping parents to keep children in their own homes through the provision of homemakers need not be too difficult or impractical.

Recently, in a group discussion I asked a State director of child welfare and the State child-welfare consultants whether they knew of families and of children where homemaker service would have been discussed with the parents as an alternative to placement if funds had been available for it. They told me of numerous instances in which children and parents had been needlessly separated.

We then tried to identify the qualities we would consider suitable in a homemaker for one of the families described and how we could go about finding her. The group expressed the opinion that imaginative workers could find women of this type in most rural counties. One consultant reported that one day, as she was leaving a county courthouse, she ran into a woman who was a casual acquaintance. When the consultant asked her what she was doing, the woman said she was taking care of children in a home where the mother was ill and had given similar service to many families in the county ever since her training as a WPA housekeeping aide in the thirties. This set the State consultants to wondering whether other women in their counties would be interested in such employment if a plan for homemaker service existed. From such simple beginnings as this a homemaker service can grow and flourish.

In many instances the agency seeking a woman to help a particular family hopes that, if she is satisfactory, she will continue to give this service as the need arises even though the agency cannot guarantee her continuous employment as a homemaker in its child-welfare program. Under such circumstances, agencies will have to look for women who have some basic income or to work out other alternatives such as using the homemaker more flexibly and in a variety of situations, finding other tasks that she can carry out in the program, or paying her a retaining fee when she is not employed.

Through building up a service in this way State and local communities can learn to appreciate what the help of a homemaker can mean to a family. In some instances, communities will continue with an informal type of service for many years. In others, they may decide on a more formalized program rather quickly, employing one or two women full time and with a guaranteed salary. Or the two methods may be combined, the more rural parts of the State continuing to use the informal arrangement occasionally while an urban center undertakes a more organized service. Out of both of these approaches can be shaped the homemaker program of the future.

To get a formal program started involves community planning. In some places the service is initiated by one agency as an integral part of its total casework program. In such instances, decisions about the breadth of service, who can use it, and the policies involved are determined by the board and executive of the agency.

In other communities the focus is on broader community needs. This calls for a planning group to take responsibility for the initial steps in developing the service, such as finding the extent of need, setting the goals, establishing policies and practices to be followed, and determining the immediate coverage to be given, the size of staff required, and the method of financing. Whatever the auspices for the community-wide program, its planning and continuance are likely to progress better if its leadership is widely representative of the professional and citizen groups interested in the community's health and welfare, the exact composition of the group depending on the particular place. No one pattern is applicable to all communities.

The Question of Cost

Fear of the cost of homemaker service also blocks the development of such service. It is difficult to give an estimate, for thus far no agreement has been reached on the items to be included in a cost figure. Such questions are involved as: Do you charge to homemaker service or to the total program of the agency the cost of interviewing all people who ask

for a homemaker, whether or not the original suggestion for this has come from the agency? Questions of this nature must be answered, perhaps by the national standard-setting agencies, before we can arrive at a satisfactory answer on cost. Further work in defining costs is important, if communities are to be encouraged to offer this type of service.

Nevertheless, there is some reason to believe that the cost of homemaker service is no greater in dollars and cents than the cost of a placement program and certainly is far less in emotional damage to the children involved. One large public welfare department with a well-organized program maintains that its homemaker service "conserves public funds by keeping children and older persons in their own homes at less cost than in institutions."

In the same city a recent report to the mayor on a study entitled, *Children Need Families*[1] had this to say: "Consider only the relative cost of homemaker service and care of children outside their own homes. Children in placement cost the city an average of $1,200 per annum; there are two or three children (on the average) in every family applying for homemaker service. A homemaker's salary averages $3,000 a year. In other words, we can keep children in their own homes without spending a penny more for homemakers than for the admittedly less desirable course of placement, with all the attendant heartache of a family dispersed, with the very future of this family problematical."

Another report from a county department of welfare employing 25 homemakers includes this statement: "A homemaker conserves tax funds by keeping children and older persons in their homes rather than in necessarily costly institutions."

Conservation Value

The central point in the consideration of homemaker service is, however, not its effectiveness in conserving the tax dollar, but in conserving the home life of children. Without it communities face a heavy toll in family breakdown, with all the resulting emotional and personal distortions that can bring so much immediate and future unhappiness and insecurity to children. The long-range outcome can only be surmised.

When family breakdown threatens because of the absence or illness of one member of the family, homemaker service can be a major defense against it. The first thought in helping a family in a crisis—providing the family is willing—should be to explore the possibilities of the children's remaining in their own homes rather than immediately moving them out into foster care. The advantages of keeping children in their own homes, when possible, should be so much a part of professional thinking that social workers would find it impossible to remove a child from his own home if even one parent is capable of providing suitable care for him at home through the help of a homemaker service.

Closely allied to this concept is the belief that most parents want to give good care to their children and should be helped in fulfilling this responsibility when they need help. Granted that foster care is sometimes required, it should be resorted to only after the strengths of the family have been assessed and the needs of the children determined as accurately as possible. When separation is threatened the agency to whom the family has come for help should examine three questions: Would it be better for the children to remain in their own home through the help of a homemaker and caseworker? Would the parents welcome such a plan? Can the parents and the agency join hands in making this possible?

A child needs two parents, it is true. But at least for a temporary period one parent is better than none; the loss of the companionship of both parents represents a double tragedy in the life of a child.

Today many fathers share in the responsibilities of the home to a far greater extent than formerly. Sometimes professional workers tend to minimize the place of the father in a child's life or the warmth of the relationship between a child and his father. At a time when children are undergoing the traumatic experience of separation from their mother, it can only be adding to the injury and danger to take them away from their father also.

Somehow professional workers must find a way to help communities recognize the importance to a child of his own home so that they will make homemaker service an essential part of community health and welfare programs throughout the United States. Such a service is not a frill to be considered as a possibility after all the other essential services required are made available. It is a major line of defense for children whose security is threatened.

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[1] Epstein, Henry: Children need families, a second look at delinquency prevention. A report to the Mayor, City of New York, 1956.

In Texas special, and successful, efforts in behalf of hard-to-place children have underscored some principles for . . . . .

PLACING THE OLDER CHILD IN ADOPTION

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TODAY, the number-one challenge to child-placement agencies is to find new and improved ways of bringing together children with special needs and couples interested in being responsible adoptive parents to them. Older children—those between 6 and 14—who are without parents most certainly have special needs. However, progressive child-placement agencies and their board members are no longer saying older children cannot be placed for adoption, for many such children are being placed with considerable success. Social workers are giving more and more credence to the theory that any child who needs a family is adoptable if he can develop in a family setting and if a family can be found which will accept him. This presupposes that the child's own parents are unable or unwilling to keep him, and that the child is ready and has the capacity to accept new parents and to adjust to a new home.[1]

In Texas our experience has convinced us that older children can be successfully placed for adoption through competent agencies recruiting adoptive homes with special qualities.

In 1956, of 473 children placed through the 20 county child-welfare units in Texas, 45 were above the age of 6. Among these were 27 Latin American children and 13 Negro children. Twenty-four of the children were placed along with at least one brother or a sister, sometimes with more. We have proceeded under the policy of gearing adoption intake to the needs of the children in the custody of the State Department of Public Welfare who are legally free for adoption and who are diagnosed as adoptable.

It is surprising how easy it has been to find homes for school-age children. In spite of the fact that we have about 10 children of this age group available for every couple interested in adopting them we have had considerable success.

One of the factors behind this success has been the State Adoption Resource Exchange, set up in 1949. The public child-welfare units are required to register with the Exchange children available for adoption and families seeking children. Invitation to participate on a voluntary basis, regularly or occasionally, has been extended to the 22 licensed private children's agencies in the State. A few out-of-State agencies have also participated.

We have developed a form known as the "profile on children" and one called the "profile on adoptive family." These forms, which list items such as religion, coloring, intellectual capacity, and health, are sent to the State office of the Public Welfare Department where a preliminary matching job is done. The unit or agency with the child is sent a copy of the profile of the family which seems best suited to the needs of the child. Records are then shared between the agencies or units involved and a decision reached. The couple usually goes to the locality where the child is living for final presentation and placement. Followup supervision of the placement is carried out by the agency which referred the family.

Though there are still some kinks in this procedure we have been more than satisfied with the results.

We know we are taking certain calculated risks in this program. However, for the sake of the children we feel we can allow adoptive parents to take these risks with us if they are willing to do so. Along with most adoption workers, we have been convinced by evidences of the effects of maternal deprivation that the earlier the placement the better the child's chances for successful adoption. Nevertheless, we also believe that the warmth and acceptance of the right adoptive parents in a community with favorable attitudes can heal many of the psychic wounds suffered by a school-age child.

The formula is simple—the right home plus the right community equals a happier school-age child who becomes a productive, happy, social adult. The definition of "right" presents the difficulty. Much remains to be learned about this. But since children cannot wait until all the gaps in our knowledge are filled and our skills are perfected, we are proceeding cautiously on the basis of what has already been learned and tested by ourselves and others.

Points To Remember

We will assume for the purposes of this paper that good casework help has been given the natural parents and that the release of the children with whom we are concerned has a valid legal and social casework basis. Under such circumstances we have found the fundamental points to remember in working with an older child to be:

1. The influence of the past. The child will have had experiences in the past which are exerting an influence on his behavior today. While the social worker cannot find out all about the past, she must learn as much as possible about it from all available sources and weigh its influence on the child's present thinking, feeling, and behavior. Some of this influence will be in the child's consciousness and so be accessible to the social worker, but a large part of it will be repressed into the unconscious storage compartment of his personality. Even so some of this can be defrosted by a skillful caseworker so that it will pour into the child's consciousness.

To be faced with a troubled youngster, conflicted in his loyalties to parental figures, expecting and needing help, is a great challenge. Since social casework is designed to help change attitude and behavior and to strengthen a person's grasp on reality, caseworkers are equipped to meet this challenge. They must, however, test, refine, and reshape their work by further experience and research. For this it is important to record experiences.

2. The complexity of the older child. The older he is the more complex is the child, the more problems he will have faced, and the more injuries he will have sustained. However, normal children generally have a great deal of resilience, adaptive powers, and ability to sustain equilibrium through hard times, pain, and difficulties. Generally, children are far more flexible than adults. Actually, inflexible adult caseworkers have sometimes blocked the chances for older children to have adoptive homes.

While the age at which the child sustained injury is of diagnostic importance, it is also important to remember that a child's personality is in a fluid state until he reaches adolescence. Any uprooting will bring problems and reactions but these may be only transitory and each child will react in a unique way. Some children will never be able to adapt to an adoptive home at all.

3. The child's responsibilities and potentialities. The problems facing the older child in need of placement belong not only to the adults concerned with him but also to himself. He must face them and take responsibility for his own internal feelings. He has within himself the potentialities for bringing about appropriate changes in his thinking, feeling, and behaving.

An important resource for caseworkers is a philosophy of life which can be called on in helping older children and young adults set goals and progress toward them. Facing reality is an important element of this.

Social workers cannot change unhappy pasts for children. However, a social worker can let a child know that she recognizes that "things are tough" for him; and help him to see that the past is irreversible and that the future can be brighter if he is willing to begin now to make it so. The social worker can help the child to see that, while some unhappy times are bound to come, the adoptive placement promises rewarding times for him also and that the mother- and father-to-be will be kind, understanding, loving, and permanent. She can also help him to understand that the use he makes of the placement as well as of her help will be up to him.

4. The child's changing nature. Every child is a continually changing constellation of potentiali-

ties without a fixed personality. Social workers can help to provide the environment and the emotional climate conducive to constructive change. Unless the social worker hopes and believes that under given circumstances the child will have a happier time, she is defeated from the start.

Children diagnosed as psychotic or psychopathic should not be placed in adoptive homes. They do not make good placement risks, for even loving parents have difficulty bearing with their behavior. I do not believe that a social caseworker is equipped to diagnose these conditions alone. When a child's behavior is extremely atypical for his stage of growth, it is always important for the social worker to consult with a psychiatrist after the child has been given projective tests by a psychologist.

Qualities of Adoptive Parents

Adoptive parents of older children need all the qualities that are usually deemed desirable in natural parents, with some important extras. Neville B. Weeks has described some of these in a pamphlet prepared for the Child Welfare League of America: [2]

> From the beginning of their contact with the adoption agency, the successful adoptive parents showed a genuine desire to help a child develop at his own pace and in his own way for the child's sake, not theirs.
>
> They were able to enjoy a child and to respect his individuality and independence without expecting him to show direct appreciation.
>
> They were people with inexhaustible stores of humor, fun, and resilience which helped them to survive the inevitable trials and tribulations of the first months of placement while the child tested their love for him.
>
> They seemed to have a deeply rooted spiritual faith or practical religion which gave them a comfortable philosophy of life and a basic confidence in human nature.
>
> The successful adoptive parents could accept the fact that a child who has suffered emotional deprivation as the result of a broken home experience may always bear the scars of this wound to some extent and may, therefore, never be able to change some aspects of his personality or behavior. Moreover, they had to be able to sustain any positive feelings that the older child might have about his former relationships and to permit him to talk freely about his past.

I would like to add that adoptive parents must recognize that they need to gain satisfaction in other areas than the parental role if they are to be the kind of parents their children can enjoy and want to emulate. Children should not be burdened with the full responsibility of providing the emotional support an adult needs to become well-integrated.

Diagnosis of Readiness

What then are the general criteria by which we can judge whether a school-age child can accept an adoptive placement, given the right help from his social worker and the kind of home which would meet his individual needs? In the Texas program we believe that the prognosis is good if:

1. The child has been able to relate to his own parents or to another adult in a meaningful way, showing confidence, respect, and faith in others: if he shows potentiality for giving and receiving love and for identifying with a mother- or father-figure of his own sex; if he gets along with his peers and is not "a lone wolf"; if there is some depth to his interpersonal relationships. In questionable cases in the area of relationships, psychiatric consultation may be in order. Perhaps every child over 6 who is being considered for adoptive placement should have a psychological examination.

2. The child has accepted the fact that he cannot return to his own parents, and shows some ability to measure his own worth and have respect for himself. Such a child may still have some fears and anxiety about taking on new parents and need casework help to deal with them.

3. The child can say openly or indirectly that he wants an adoptive mother and an adoptive father and can respond to the social worker's efforts to get them.

4. The child takes some responsibility for himself, recognizing that he can gain more by trying to adjust to a new situation and new parents than by resisting adjustment. He gives evidence of having a healthy conscience. He shows ability to learn from his mistakes as well as his successes.

5. The child's mental and physical capacities are within normal range. (The child who is not producing up to his capacities may also be adoptable if the deviation is not too great. The services of a physician and a psychologist can help measure these potentialities.)

6. The social worker believes adoptive placement is right for the child. (If she does not, she will not be able to help the child or the adopting couple.)

These criteria need to be tested against carefully evaluated experience and used with wisdom and good judgment. They simply offer a start in identifying the qualities of growing personalities which seem most favorable for successful adoptive placement. Other points may be added and clarification made as to how the absence of one or more of these specific ingredients might be offset.

In addition to such criteria adoption workers need some general guides on the subject of how and when to separate brothers and sisters who for some reason cannot be placed together in the same adoptive home.

Treatment Goals and Processes

Because preparation of the child for placement is an individual process, the various possible approaches must be subject to adaptation, according to the needs of the child. Each child will react in his own way to separation and to new relationships.

We have, however, identified five treatment goals in working with older children being placed for adoption:

1. *To help the child see the reasons for placement and to handle his reactions to separation from his own home.*

This should be tackled as soon as possible in order to prevent pathological repressions and fixations. It can be accomplished only when a true casework relationship has been established with the child.

Experience has shown that with an older child who has a living parent it is better if the parent lets the child know he approves the plan for adoption. However, it is unusual for a parent to be able to do this. In very rare instances the child might sit in on interviews with the parent and social worker. This would be a way of letting the child know the social worker is acting in behalf of his parents for the child's best interest. It is not usually a wise plan, however, especially in cases where children have been so severely neglected that court action has been taken and where neither parent can accept responsibility for participating in the plan to release the child.

After the child is in the agency's custody he should be encouraged to talk frankly about his parents. If the child is to understand the reasons for separation and need for placement the caseworker too must talk about the parents but without passing judgment, spoken or implied, on them. Perhaps the caseworker can relate their inability to be parents to difficult childhood experiences—something the child can understand. Both the social worker and the child must realize that the child's loss of his parents is a painful fact that cannot be changed or altered and must be faced, understood and somehow philosophically accepted.

Children need help in living through an experience of this kind. They may have to play it out if they cannot talk about it. They will not be able to move on to the new until they assimilate the old and are able to leave it.

Not all children who remember their parents can be helped to accept the fact that their parents have given them up forever. However, the degree to which a child can accept this is dependent upon a combination of factors: the age and stage of development of the child at the time of separation; the demonstration of interest or lack of it on the part of the parent following the initial physical separation; and the type of circumstances—such as desertion, death, or imprisonment—bringing about the separation.

The degree of the child's reactions to loss of his parents may eventually be mitigated by the security and positive relationships provided by the new family.

Because separation under any circumstances means desertion to a child, the child who has been freed for adoption feels he is somehow not worthy of love and has secret fears that something must be wrong about himself. This is why he needs to experience a relationship he can trust before he can trust another. The social worker can help him experience this through the quality of her own relationship with him.

The child must sense through verbal and nonverbal communication that the social worker likes him and cares what happens to him and that she represents the agency which stands by always to assist him. Sometimes the social worker can help achieve this sense of trust through tangible gifts of candy, chewing gum or toys, and treats at the corner drug store. For many children a gift is a proof of love.

In order to be able to trust again the child who has suffered from disappointment at the hands of many adults needs to find someone with whom he feels free to be himself; who accepts him whether he is good or bad. The social worker must demonstrate to him that she does care about him and what happens to him; she must always keep all her promises to him. Somehow she must get across the fact that she can be trusted and that there are other adults who can also be counted upon.

2. *To prepare the child for placement in his adoptive home.*

The child needs to feel that the worker understands he has many different feelings about the adoption. The prospects of going to a strange home with un-

known adults, a new school, and a new community and of making new friends are frightening. The social worker can let him know she understands his fear and can help him conquer it.

This can only be done gradually, a step at a time. The child can be told about the new home, the neighborhood, the school, what his room will be like, and what the boys and girls in the neighborhood are like. He can be assured that the new mother and father will know about him and will be interested in him and want him to like them. He must be told, too, that there will be times, even after placement, when he will be unhappy, but that he will be with people he can trust and that he can grow to be happy if he gives them a chance to love and care for him. He must also be told that the new parents will discipline him, but that this will be because they love him.

The social worker should make it clear to the child that she wants him to feel as comfortable as possible about going to live with his new family before final placement is made. In some instances, weekend visits with the adoptive family are possible and the child can discuss his reactions to them with the caseworker. Sometimes the family comes to the locality where the child is to spend a week or more before the final placement is made. In such instances, the child and parents-to-be should be given time to be alone together without the worker being present.

The key to the actual move will be the child's readiness for it. The child will usually be interested in the fact that those responsible for his care, such as his foster parents or institutional houseparents, approve the adoption plan. He should have a choice about retaining or changing his first name and be given some selection in what he will call his new mother and father.

3. *To prepare the adoptive parents for accepting the child.*

To fail in this is to borrow trouble. The caseworker can suggest that adoptive parents think over what they have observed in other children of the child's age. She must describe the child to be adopted, telling about his medical and social history, and his current medical needs, if any. She should emphasize the positives in the child's background and the effect they have had, or are likely to have, on the child.

The social worker should also try to give the adoptive parents a sympathetic understanding of why the child's biological parents cannot carry the parental responsibility. She should also help the adoptive parents to examine their own feelings about parents who are immature and inadequate and who have neglected their children, and to come to accept the negative factors present in the child's background. She should encourage them to allow the child to discuss his memories and, by remembering their own childhood feelings about separations, to learn not to react to his reminiscences with anxiety. She can also encourage them to remember their own childhood feelings when faced with new situations and separations.

The caseworker must help the adoptive couple understand that bringing up children is complicated; that there will be times when their patience is exhausted as there are with natural parents; that the child will sometimes regress in his behavior in ways that will not easily be understood; that he will need to test their love; and that seeking help from the social worker will not represent failure on their part but, on the contrary, will be an indication of good parenthood.

4. *To present the child to the couple in the most effective way.*

This requires careful thought. Experience has shown that an older child should be protected from the adoptive parents' reactions to the first sight of him. Arrangements might be made for them to see him across the counter at a toy shop, at the zoo, or in the agency office before an actual introduction is made. Thus the child will be protected from the force of his first impact on them and possibly from another experience of rejection.

Prospective adoptive parents carry an image of the child they want even though they may not be aware of this. They need to be helped to realize that no child is going to match this image and to be given a realistic view of what to anticipate. Some couples react quickly after seeing a child in making their decision about him, while others need more time. The caseworker should not push them into a quick decision nor allow it to drag on indefinitely.

The child should be made to look as attractive as possible for the first presentation as first impressions are lasting ones. The meeting should be as casual as possible.

A series of short visits to the adoptive home before placement can be particularly helpful to children over 12 years of age. However, a child of this age, or even younger, is apt to guess the reason for the visit. Perhaps it should be explained. After

the visits, discussions need to be held with the child about whether the visit provided him any satisfactions and how he liked the people. Such visits should not take place until after the adoptive parents have reacted favorably to what they have been told about the child and to their first view of him.

The worker can also let the child and couple know some of the questions which will be directed to them by people in the community and can suggest answers to them.

5. *To give maximum casework help during the adjustment period.*

Problems around authority, behavior, and competition with peers crop out repeatedly in older children. The worker can help the family distinguish between what is normal behavior and what arises from placement or as a result of a deprived background and so needs special handling.

The school and the total community play a large part in the older child's adjustment to adoption. Every child-placement worker knows of evidence of peer cruelty from youngsters with impulses to control and dominate others. The formation of cliques with exclusion of other children is a normal phenomenon with preadolescent children. The caseworker can help adoptive parents help their children to handle these problems as well as problems associated with the physical and emotional changes that come with adolescence.

Adoptive parents of adolescents need to be able to accept the fact that their child is coming to them at an age where it is normal for children to begin to emancipate themselves from dependency on adults and to understand that the typical adolescent tends to rebel at the authority of parents and teachers.

Research Project

Time alone can tell how well the principles described here are serving the children for whom they are applied. In Texas we have great faith in the feasibility of adoption for older children who do not now have a normal family life. But we want to know more about how this can best be achieved for them.

Therefore the Texas State Department of Public Welfare is planning an exploratory research project on followup of older children placed in adoption by the child-welfare units. Special note will be made of children in sibling combinations. The research team will include our State psychologist, the director of field staff, and the supervisor of licensing who is the former consultant on foster-family care. We look forward to some interesting results from which we can draw evidence to improve our diagnosis of a child's readiness for placement as well as to determine the factors which make for success or failure in the adjustment of adopted children placed at 6 years of age or older.

That success, in varying degrees, is possible we are sure, and we are eager to sharpen our tools for achieving it to the maximum.

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[1] Citizens Committee on Adoption of Children in California, Los Angeles: A citizens committee looks at adoption of children in California. Final report. 1953.

[2] Weeks, Neville B.: Adoption for school-age children in institutions. New York: Child Welfare League of America, October 1953.

CHILD WELFARE IN A RURAL AREA

What a challenge it is to help develop resources and change attitudes. You take every opportunity to speak to every group that asks you. You talk foster homes, child care, mental-hygiene clinics, better schools, foster homes, foster homes, foster homes until your friends and foes think you have only one theme. You teach Sunday school, sing in the choir, bake cakes for food sales, sell tickets for the barter theater. You visit the jail on a Saturday night just as you are deep in a bridge game because one of your teen-agers has gotten drunk at the square dance. You talk to people who drop in on you on Sunday afternoon to discuss adoption. In other words you are so closely tied up with the community after a few years that you will never get away and you don't want to.

From a letter written by a child-welfare worker to her professional alma mater.

PROJECTS AND PROGRESS

Conferences on Mentally Retarded

Two regional conferences on mentally retarded children have been held since the first of the year under the sponsorship of the Children's Bureau and State health departments, for the personnel of State health services. The first, which was sponsored jointly by the Bureau's office in Region VIII and the Colorado Department of Public Health, was held in Denver, February 1–3. It brought together physicians, public-health nurses, social workers, psychologists, educators, institution directors, and parents, from five Rocky Mountain States—Colorado, Idaho, Montana, Utah, and Wyoming. The second, co-sponsored by the Virginia Department of Health and the Bureau's offices in Region III and IV, assembled a similar group from 12 southern States, Puerto Rico, and the Virgin Islands. A third regional conference is to be held in Dallas in May.

At the Denver conference attention focused on the planning and coordination of services to the retarded as part of a community's overall program for the health and welfare of children, with careful consideration given to definition and content. Speakers at the general sessions described the roles of various official agencies, voluntary groups, and specialized services in contributing to such an overall program.

A feature of the conference was a general session devoted to a clinical case presentation and evaluation of two Denver children by a team of seven specialists from the Morris J. Solomon Clinic of the Jewish Hospital of Brooklyn. The members of this team also made themselves available as resource people to the sectional meetings for each of the professional groups.

The sectional meetings centered on the part each profession could play in prevention and in improved services. The physicians discussed ways in which pediatric and obstetric services, especially in maternal and child-health clinics, could help prevent at least some instances of mental retardation. The social workers gave major attention to the need for individualizing social services for mentally retarded children, expressing concern, for instance, over the fact that knowledge and skills already developed in connection with the placement of children often are not applied when a mentally retarded child is separated from his parents. The nurses focused on ways and means of learning and using techniques in helping parents train mentally retarded children at home. The psychologists centered on problems of evaluation stemming from the inadequacy of tests in giving a complete picture of a child's potentials.

The conference in Washington confined attention to the public-health aspects of mental retardation. Speakers presented material on the etiological factors involved and on what is known about prevention, especially of cases in which the condition is determined in the prenatal period of life. In addition, a number of panel presentations described how the various professions represented on a public-health team could provide and coordinate services to mentally retarded children and their parents.

In recognition of the fact that many States have no special projects for the mentally retarded, the panel discussions focused largely on what could be provided through on-going health services and facilities for the general population. However, one panel, composed of the staff of the Consultation and Evaluation Clinic for Children, in Richmond, Va., presented the conferees with an example of how a small-scale project, set up with community support, could be established and operated.

Social Research

With an eye to its eventual usefulness to the Social Security Administration, U. S. Department of Health, Education, and Welfare, the Community Research Associates, a nonprofit voluntary organization, is developing information on the kind of research now being carried on or currently needed in connection with public welfare. Purpose of this research survey, which is being financed by funds from the Grant Foundation, is to help the Social Security Administration prepare for the administration of the kind of cooperative social research and demonstration program authorized in the 1956 amendments to the Social Security Act.

The legislation allows Federal funds, if appropriated, to be spent for grants to the States and other public and voluntary nonprofit organizations for paying part of the cost of research projects "such as those relating to the prevention and reduction of dependency, or which will aid in effecting coordination of planning between private and public welfare agencies, or which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto . . ."

To avoid duplication of effort CRA will make available the results of its inventory to the Children's Bureau Clearinghouse for Research in Child Life and the Bureau of Public Assistance's "Digest of Special Studies Relating to Public Assistance."

Concerning Courts

As part of its recommendation for a simplified statewide court system, New York State's Temporary Commission on the Courts is suggesting a plan to end fragmentation of jurisdiction over matters affecting family relationship and children in New York City. Cases of this type, now handled in the domestic-relations court, city magistrates' courts, court of special sessions, and other courts, would be handled by the supreme court if the recommended plan were adopted. Matters affecting youth covered by the 1956 Youth Court Act would also be under the jurisdiction of the supreme court. Among the cases to be added to those now handled by the supreme court would be those concerning protection, treatment, custody, commitment, and guardianship of minors; divorce and annulment of marriage; relinquishment or termination of parental rights, adoption, paternity, support of dependents, and commission of certain crimes against children. All such cases, except contested divorces, would be handled in a family division of the supreme court.

The commission has also recommended reorganization, though on a less comprehensive basis, of the courts in other parts of the State. Adoption of its recommendations would require amendment of the State constitution.

World Health

The United States Government, through the International Cooperation Administration, recently made a special contribution of $1,500,000 to the Pan American Sanitary Bureau's special fund for malaria eradication. The money is to be used for: the assignment of technical personnel for work with governments on antimalaria projects; the provision of training opportunities for technical personnel; technical direction and coordination of the program; technical advisory services to governments; evaluation surveys; and other services to help promote and expand government malaria-eradication programs. Other funds going into the all-out effort to eradicate malaria in the Western Hemisphere are available in the Bureau's regular budget and in allocations from the World Health Organization and from the United Nations Technical Assistance program. The United Nations Children's Fund is contributing to the effort through the allocation of supplies and materials to the governments involved.

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The International Confederation of Midwives, a nongovernmental body, was recently admitted to official relationship by the World Health Organization.

Education

In anticipation of greatly increased demands for all phases of post-high-school education, the President's Committee on Education Beyond the High School, which was appointed in March 1956, is asking for comments from laymen and educators on its preliminary conclusions and plans to modify them if necessary in the light of such comments. Among the steps recommended by the committee's first interim report are: improving guidance programs; encouraging women to continue their education beyond high school; providing post-high-school institutions with the needed teachers, buildings, and funds; broadening and diversifying the range of post-high-school opportunities; making less rigid the time requirements for high-school and other courses; employing a greater number of able, qualified teachers; constant attention to the quality of instruction; and formulating an explicit, considered policy on the Federal role in post-high-school education.

The committee notes that by 1970 the number of students in colleges and universities will double and may triple the current 3-million attendance figure, and that other millions will seek to be served by correspondence schools, private resident schools, apprentice-training courses, and other educational programs.

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Classroom shortages in public elementary and secondary schools in continental United States amounted to 159,000 rooms at enrollment time last fall, according to State figures reported to the Office of Education, U. S. Department of Health, Education, and Welfare. The State figures show that 2,295,000 pupils were enrolled in excess of the normal capacity of the school buildings. These pupils, the Office reports, were assigned to half day or "double shift" sessions, to makeshift facilities, or to overcrowded rooms.

Institutions

A project to help children's institutions improve their work, especially through inservice training of houseparents, is being carried on in six Southeastern States by the University of North Carolina's School of Social Service under the auspices of the Southeastern Conference of Workers in Homes for Children. Known as the Group Child Care Project, it began operations June 1, 1956; is staffed by two workers—a part time director and a full-time consultant who is also associate director; and is financed through contributions from about 20 member institutions plus matching funds provided by the Duke Endowment.

At the request of member institutions the director schedules week-long visits by the consultant, who discusses with an institution representative the kinds of help needed and then plans the week's work jointly with him. During the visit the consultant shares the daily lives of the children and the institution staff; talks with individual staff members, such as the executive, caseworkers, houseparents, teachers, nurses, farmworkers, and dietitians; conducts workshops for houseparents; and holds sessions with the whole staff.

Reporting on the first 6 months of the work, the director states that though the project's main emphasis is on houseparent training, the institutions showed interest in receiving help in other areas also. Four of the 10 institutions visited asked for extensive study of their programs, and one asked for help in revising its written policies on intake and casework responsibility. The director notes further that the service provided to the institutions is not evaluative or concerned with standard setting, but is entirely an effort to help fulfill some of the individual needs that the institutions are unable to fulfill themselves.

Nonresidents

The President's Committee on Migratory Labor, appointed in August 1954 to aid Federal agencies in mobilizing and stimulating programs for improving living and working conditions for crop-following agricultural workers and their families, recently issued its first progress report. The report sets forth guides for the agencies in planning for migrants, notes various phases of the committee's activities, and suggests minimum standards for agricultural labor camps and draft legislative language for regulation of such camps. It also includes: a proposed code for regulating transportation of agricultural workers and information for employers on tax deductions allowable for expenses incurred in furnishing benefits to seasonal agricultural workers.

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Not quite $6 million in public funds was spent in New York State in 1955 to care for an estimated 20,000 nonresidents. New York is one of the few States with no residence requirements for the receipt of public aid.

The State Department of Social Welfare reports that about 1/500 of the estimated 16 million nonresidents who come to the State annually become needy and are given temporary aid, such as hospital care, institutional care, or financial assistance, by the State, with about 12 percent of the money coming from the Federal Government. More than one-fifth of the 1955 expenditures for nonresidents went for institutional or boarding-home care for children without parents or guardians.

One-third went for hospital and medical care and one-half for financial assistance.

About 2 percent of the nonresidents in the State aided by public funds in 1955 were seasonal migratory workers or members of their families. Of the 32,752 migrants in the State that year 417 received public aid, at a cost of $79,297—a little over one tenth of the total expenditure for public aid for nonresidents. The greatest proportion of this expenditure went for hospital care—$60,433; the rest for medical care and burial services.

The department notes that the number of nonresidents receiving public aid in 1955 was 7 percent lower than in 1954 and that preliminary data indicate another 10 percent decrease for 1956. In 1955 the nonresidents averaged 1.8 percent of all persons receiving public aid in the State.

Adoptions

California's State Department of Social Welfare recently received $2,000 and an inscribed scroll from Marshall Field Awards for "the marked extension and increased services to children needing adoption." The awards committee cited the Department's efforts to extend adoption services to children with special needs and to those of minority groups, its use of public funds for adoptive services under the Refugee Relief Act, and its participation in a cooperative effort with citizens committees and private agencies which has resulted over the last 10 years in an increase in the number of licensed adoption agencies from 2 to 25 and in the number of children placed in adoptive homes from 598 to 2,157.

Because of the death of their donator, Marshall Field, the awards, made for the first time this year, will be discontinued. Five of the 7 awards went to individuals; the other to Station WFIL and WFIL-TV in Philadelphia for pioneering in the use of radio and television in the schools.

* * *

About 93,000 petitions for adoption of children under 21 years of age were filed in the United States during 1955, according to an estimate made by the Children's Bureau. The figure is based upon reports from 39 States, 31 of which provided detailed classification of data from the petitions filed.

In the States reporting completely 52 percent of the petitions were filed by prospective adoptive parents not related to the child. In this group 56 percent had been placed in the adoptive home by social agencies; 14 percent had been placed independently 21 percent by parents or other relatives, and 23 percent by nonrelated persons.

The median age of the children as a whole at the time they were placed in the adoptive homes was 3.7 months. Those placed by social agencies had a median age of 5 months; those placed independently by relatives, of 3.1 months; and those placed independently by nonrelatives, of less than 1 month.

* * *

A 2-day conference of adoption workers, allied professionals, and community leaders, held in San Francisco in March, stressed the need for agency flexibility in adoption practices, and more positive programs of community relations in order to solve the problems of adoptive placement of children of minority groups. The conference was sponsored by MARCH, cooperative project of San Francisco Bay Area agencies, concerned with stimulating adoption opportunities for such children. Recognizing the progress made in the area in making services available to more children, the conferees also discussed new genetic and anthropological insights, and recommended that agencies give top priority to adjusting practices to present-day needs.

Health Protection

The cost of fluoridating city water supplies as a protection against tooth decay in children will soon be lowered because of a new device for city waterworks developed by the Public Health Service, U. S. Department of Health, Education, and Welfare. The device, which will permit use of fluorspar, the least costly form of fluoride, will lower the cost of fluoridation from 10 cents per person per year—the average cost in most parts of the United States—to 3 cents.

Reports to the Public Health Service indicate that fluoridated drinking water is now available to one-fourth of the people using public water supplies in this country—over 30 million persons in more than 1,000 municipalities.

* * *

More than 150 medical, dental, and civic leaders have joined together to form a group called the Committee To Protect Our Children's Teeth, Inc., with headquarters at 105 East 22d Street, New York 10, N. Y. Its purpose is to spread facts and correct misinformation on fluoridation of water supplies to prevent tooth decay.

* * *

To help hospitals to improve their care for patients who need only limited services and to reduce costs for such patients an advisory committee appointed by the Secretary of Health, Education, and Welfare is working to develop methods of adapting facilities and services more closely to the varying needs of patients. Among the adaptations being considered are: hospital units in which patients could provide more services for themselves and rooms designed for patients who need only part-time hospitalization but who now pay for 24-hour service.

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Grants totaling $92,000, received from foundations and anonymous donors, are enabling the American Social Hygiene Association to carry out a nationwide study of venereal disease and promiscuity in teen-agers.

The study will include the following aspects: investigation of teen-age attitudes toward sex and venereal disease and of teen-age sex-behavior patterns; identification of frequency patterns of venereal-disease infection and reinfection among teen-agers; study of the social and economic factors that may predispose teen-agers to promiscuity; inquiry into the source of teen-agers' information on sex and venereal disease.

The study, expected to take more than 2 years, will be conducted among a variety of ethnic groups in both rural and urban environments and in areas of both low and high incidence of venereal disease.

According to the Public Health Service, U. S. Department of Health, Education, and Welfare, 21.3 percent of reported cases of infectious syphilis in 1955 occurred in persons aged 1 19. This represents a slight reduction from the figure for 1953, when 22.1 percent of such cases were found in that age group.

* * *

The volume of health services provided for mothers and children under State-Federal programs in 1955 in general remained the same as it was in

1954, with slight rises and decreases in some services, according to reports received at the Children's Bureau. Figures for some types of services, such as nursing visits, reached new highs, but these represented more intensive service rather than more recipients.

About 189,000 expectant mothers received medical services at clinics. Almost 251,000 received nursing services at home or in the nurse's office. After childbirth 54,000 mothers received medical examinations; 209,000 received nursing services. About 448,000 infants were brought to well-child conferences. Similar conferences were attended by 577,000 preschool children. About 723,000 infants and 779,000 preschool children received nursing services. Medical examinations were given to 2,331,000 school-age children. Over the years more and more of these examinations have been held with the parents present.

Diphtheria immunizations amounted to 2,058,000, mostly given to infants. It is noteworthy that the number of infants so immunized represented 14 percent of the number born that year—more than twice the percentage that received them a decade ago. The total number of smallpox vaccinations came to 1,893,000.

Other services provided under some of the maternal and child-health programs include dental services, supervision of midwives, care of premature infants, pediatric clinics, and various types of group instruction, such as maternal- and child-care classes.

Crippled Children

More handicapped children than ever before received medical care under State-Federal crippled children's programs in 1955, according to reports received by the Childrens' Bureau. The number of such children—278,000—represents a 3 percent increase over the figure for the previous year and a 250 percent increase over that for the first year of the program's operation, 1936. During that first year, 2.4 per 1,000 children under 21 years of age in the United States were served by the program; in 1955 the rate was nearly twice as high—4.5 per 1,000.

In 1955, as in previous years, congenital malformations, diseases of the bones and organs of movement, and poliomyelitis (chiefly its later effects) led all handicapping conditions among children served. Among these conditions only polio has declined as a cause since 1950. In 1950 about 6,200 children with acute polio were cared for; in 1955 the number had dropped to less than 3,300, though the children with the later effects of the disease numbered about 25,000. Since 1955 was the first year of release of the Salk vaccine, figures for that year do not reflect the full impact of the immunization program.

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The National Society for Crippled Children and Adults is offering scholarships to provide inservice training, refresher courses, and short- or long-term university or technical-school training to Hungarian refugees in this country with appropriate professional background for work with crippled children. The scholarships are available to refugees with basic training in physical, occupational, or speech therapy or in a field of medicine related to rehabilitation of the crippled.

Juvenile Delinquency

In January the Senate by resolution authorized the Committee on the Judiciary to continue its study of juvenile delinquency using no more than $50,000 for expenses during the period beginning February 1, 1957, and ending January 31, 1958. Among the subjects that the Committee's Subcommittee to Investigate Juvenile Delinquency expects to study are: treatment facilities for young narcotic addicts; progressive community programs for the prevention, treatment, and rehabilitation aspects of the delinquency problem; traffic in the types of weapons used by juvenile delinquents; application to Federal legislation of provisions of New York State's Youthful Offender Act; institutions for children and youth, especially those with serious mental disturbance.

Census Reports

Recent estimates of the Bureau of the Census, U. S. Department of Commerce, indicate:

The population of the United States included 57,436,000 children and adolescents under 18 years of age on July 1, 1956. From April 1, 1950, to July 1, 1956, the number of children under 5 years of age increased by 15.6 percent; the number 5 to 9 years of age inclusive, by 37 percent; and those 14 to 17 inclusive, by 13.5 percent.

Population estimates for 1955 show that while the third of the States with the highest incomes included the greatest number of minors, in this group of States the population under 21 represented a smaller portion of the group's total population than in the lower-income States. In that year the third of the States with the highest incomes had 355 minors per thousand population; the middle third in respect to income, 390 per 1,000; the low-income third, 436 per 1,000.

Family income in the United States averaged about 6 percent higher in 1955 than in the previous year. Prices were fairly stable during this period, according to the Department of Labor's Consumer Price Index. The estimated median income of the Nation's 43 million families in 1955 was $4,421; in 1954 it was $4,173. In 1955 for nearly one-fifth of the families (7.5 million) the income was under $2,000; for more than two-fifths (18,000,000) it was $5,000 or more.

Households in the United States amounted to 48,800,000 in 1956, an increase of 5,200,000 over the number in 1950, or 872,000 a year, according to the Bureau of the Census, Department of Commerce. Farm households decreased by 104,000 a year during the period 1950-56, and nonfarm households increased by 976,000 a year in the same period.

Vital Statistics

A number of factors are associated with completeness of birth registration in the United States, including place of birth (home or hospital) and age and race of the mother, according to an analysis made by the National Office of Vital Statistics, U. S. Department of Health, Education, and Welfare, of birth-registration figures for the first 3 months of 1950, the most recent census year.

Practically all hospital births were registered (all but 0.6 percent) the analysis shows, but nearly 12 percent of births at home were not. Registration was over 98-percent complete for infants born to women in the 20- to 24-year age group, but fell below that figure for those born to women in higher and lower age groups. A smaller proportion of certificates were filed for infants born to nonwhite than to white mothers, chiefly because relatively fewer of the nonwhite were delivered

in hospitals. Birth registration was least complete for American Indians. Over one-fifth of the Indian mothers were delivered by nonmedical attendants, who filed certificates for less than half the infants they delivered.

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An improved system of collecting marriage statistics was recently adopted by the National Office of Vital Statistics and more than half the States. The cooperating States will obtain regular reports from local officials and make periodic tests of the completeness and accuracy of their marriage registrations. The marriage-registration area thus established will be comparable to the birth- and death-registration areas from which national statistics have long been collected by the Federal Government. A Divorce and Annulment Registration will be added soon.

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About 4,200,000 babies were born in the United States during 1956, nearly 3 percent more than the number born in 1955, according to an estimate by the National Office of Vital Statistics. The birth rate for 1956 was 25.1 per 1,000 population, slightly higher than the estimated rate of 24.9 for 1955. The birth total for 1956 sets an alltime record.

When detailed figures become available, the NOVS suggests, they will probably show that the 1956 increase is due both to a rise in the number of couples having their first child and to an increase in subsequent births. Ordinarily a year when the number of marriages increases is followed by a year in which the number of first babies increases. From 1954 to 1955 marriages rose by an estimated 3.3 percent.

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A recent survey by the Public Health Service, Department of Health, Education, and Welfare, indicates that of every 1,000 babies born alive among American Indians, 65 die in the first year of life, as compared with 27 such deaths per 1,000 live births in the population of the United States as a whole. The survey also indicates that: the death rate from diarrheal diseases is 11 times higher among Indians than among the general population; from tuberculosis 5 times higher; from pneumonia and influenza 3 times higher; from accidents 2½ times higher. The average age at time of death among American Indians is estimated at 39. It is 62 in the general population.

INTERNATIONAL PUBLICATIONS

THE INSTITUTIONAL CARE OF CHILDREN. United Nations, Department of Economic and Social Affairs, New York. 1956. 70 pp. For sale by International Documents Service, Columbia University Press, 2960 Broadway, New York 27, N. Y. 50 cents.

Suggestions for national and international action to help solve the problems of improving institutional service for dependent and neglected children are offered in this report, which compares institutional care in various countries.

For action by individual nations the report suggests establishment of national committees on institutional care to survey the needs of children who must live away from their own homes and existing provisions for such children; to evaluate current practices in institutional care; to set up standards for institutions; and to consider the planning of training courses for staff.

International action, the report suggests include supplying to governments at their request the services of experts in child-welfare work and in training institutional staff; providing opportunities for study abroad to directors and other institutional staff; and holding regional seminars or conferences for institutional staff and child-welfare officials.

ADMINISTRATION OF MATERNAL AND CHILD HEALTH SERVICES; second report of the Expert Committee on Maternal and Child Health. WHO Technical Report Series No. 115. World Health Organization, Palais des Nations, Geneva, Switzerland. 1957. 28 pp. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N. Y. 30 cents.

This committee report reviews administrative principles and methods as they apply to maternal and child health and examines some of the special problems in that field.

The committee recommends: That the World Health Organization convene an expert committee to consider the administrative and scientific uses of statistics and other records in MCH, including school health programs; that WHO urge governments that have not yet established national MCH units to do so without further delay, that further studies be promoted in major MCH problems of mutual concern to several countries, using standardized methods designed for comparative research purposes; that WHO stimulate the holding of regional and national conferences to study the application of the principles of MCH administration set forth in this report.

COMPARATIVE ANALYSIS OF ADOPTION LAWS. United Nations, Department of Economic and Social Affairs, New York. 1956. 28 pp. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 26, N. Y. 30 cents.

Planned as a guide in preparation of adoption legislation, this report, which is an addendum to WHO's 1953 "Study of Adoption of Children," presents factual analyses of adoption laws in 15 countries selected because their provisions for adoption reflect differing legal systems, social structures, and cultural patterns. No attempt is made to evaluate the relative merits of the various provisions or to draw conclusions.

THE PREVENTION OF JUVENILE DELINQUENCY IN SELECTED EUROPEAN COUNTRIES. United Nations Department of Economic and Social Affairs, New York. 1955. 156 pp. $1.25. For sale by International Documents Service, Columbia University Press, 2960 Broadway, New York 27, N. Y.

The study reported in this publication was made by the Institute for the Study and Treatment of Delinquency, London, at the request of the UN Secretariat. To find what measures the various countries in Europe were taking to prevent overt offenses by juveniles in danger of delinquency and to prevent recidivism among delinquents, the Institute sent questionnaires to 28 countries, 19 of which replied.

IN THE JOURNALS

Limitations Needed

Principles for casework treatment of delinquents are set forth in *Social Casework* for March 1957 by Martin Falsberg, assistant director of probation, King County Juvenile Court, Seattle, Wash. ("Setting Limits With the Juvenile Delinquent.") In the belief that a child becomes delinquent because he has not developed enough control over himself to prevent his carrying out his normal, but socially unacceptable, impulses, the author states that treatment should have as a primary goal eventual incorporation of necessary controls. Setting limits on the child's behavior, though not on expression of his feelings, is a major rehabilitative tool, he maintains.

To use this method effectively, the author points out, the worker must first understand the delinquent, must find the factors that contribute to his inability to master his impulses, and must then take remedial measures.

Institutional Costs

Preliminary findings of a study begun 2 years ago to develop a method of computing the cost of institutional care of disturbed children that would be "more meaningful, more accurate, and more comparable from one setting to another than the traditional per capita data" are discussed in *Child Welfare* for March 1957 by Martin Wolin, director of research, Child Welfare League of America.

Besides the costs of various types of treatment in a treatment-focused institution the costs need to be counted for food, shelter, clothing, medical and dental care, a supervised cottage and activity structure, and an intramural grade school, the author notes.

To find the relative costs of the various services, time records were maintained for service units (complete cases) and work units (phases in case processing), the author explains. These data also showed the mean costs of the units, which, the author points out, were the costs of work with children with various characteristics. Data were therefore analyzed to show the costs of serving children with low, average, and high intelligence and children of varying family backgrounds. The great differences found lead the author to suggest the desirability, and perhaps necessity, of considering characteristics of children in any computation of the cost of their care.

Accidental Deaths

A discussion of accidental deaths of persons aged 1 to 19 years in 12 countries in 1951–53 appears in the January 1957 issue of the *Chronicle of the World Health Organization*. ("Accidental Death Among Children and Adolescents.") In 9 of the 12 countries the rate of deaths due to accidents was more than twice as high as the rate of deaths from any other cause. In four countries the rate was three times as high as the second-ranking cause; in three, four times; and in one, the United States, five times as high. Motor-vehicle accidents led as causes of death in Australia, Canada, England and Wales, Germany, Sweden, Switzerland, and the United States. In Japan and Ceylon the chief cause of accidental death was drowning. The high place of accidental deaths among causes of death among children, the article reports, is due not only to the growing numbers of motor vehicle accidents but also to the conquest of death-dealing diseases.

X-ray Records Proposed

Steps toward curtailing the too-enthusiastic use of X-rays are suggested in the *Journal of the American Medical Association* for March 9, 1957, by two physicians on the staff of a blood-research laboratory, William Dameshek and Frederick Gunz. ("Diagnostic and Therapeutic X-Ray Exposure and Leukemia.") In line with proposals by the National Research Council and England's Medical Research Council, the authors suggest that the use of X-rays in treating many disorders be strictly reevaluated and eventually limited and that their use in diagnosing be reduced. They also urge that each X-ray given to a patient be noted in a booklet so that the cumulative record would enable any doctor to know at a glance whether the patient was beginning to exceed his lifetime quota of permissible X-ray dosage.

The authors do not suggest limiting the use of X-rays when they are clearly needed.

Causes of Retardation

Discussing causes of mental retardation, Herman Yannet, in the February 1957 issue of the *Journal of Pediatrics* points to recent apparent success in preventing two genetic metabolic diseases that affect the brain—galactosemia and phenylpyruvic disease. ("Classification and Etiological Factors in Mental Retardation.") These two diseases affect few children, the author points out, but he notes that the techniques used in preventing their clinical manifestations represent a new approach to the medical management of genetic mental disorders.

Among 2,500 persons admitted to the Southbury (Conn.) Training School for Mentally Retarded, of which Dr. Yannet is medical director, 90 percent had mental conditions that were either genetically or otherwise determined before birth, he reports. In only 10 percent was retardation due to injury at birth or later.

The largest proportion—40 percent—had inherited genes that placed them at the lowest level of the normal distribution of intelligence; their problem, according to the author, is mainly sociological. The second largest group—35 percent—had suffered before birth from nongenetic conditions for which the causes have not yet been found. The large size of this group bears witness to the need for research in abnormalities of pregnancy, the author maintains. About 10 percent had suffered from prenatal conditions not definitely determined as genetic, including some infections. This group includes mongoloids, in whose condition one frequent factor is advanced age in the mother; however, says the author, there is strong evidence to implicate some type of genetic factor as well. He adds that retardation in about 5 percent of the Southbury admissions is due to genetically determined conditions that lead to abnormal manifestation.

READERS' EXCHANGE

SHERIDAN AND BREWER: *Short-term marriage counseling in court*

I am particularly interested in the article by William H. Sheridan and Edgar W. Brewer ("The Family Court," CHILDREN, March–April 1957), since community concern here has led to a study of the desertion and nonsupport functions of our courts. Our explorations indicate that the term "family court" is frequently used but that the implications of the concept are little understood.

I believe that this article will clarify many questions which have not been clear in regard to both the concept and framework of family courts. However, no reference is made to one crucial factor, the necessity of having a judge who believes in the family-court approach and who will make the structure and resources productive for the human ends which are the goal of family-court service. Since there is no simple answer to the question of how to secure such a judge, continued active citizen support of the family-court principle is the only probable assurance of positive long-term results.

Because of my experience in social-casework service, I am particularly interested in the discussion of marriage counseling in this article. The authors describe lucidly some of the conflicting currents affecting marriage counseling in the court set-up with particular emphasis upon the conflict between the confidential demands of the counseling relationship and the role of the court employee as a functionary of the court. They leave the impression that marriage-counseling service should primarily be given outside the court.

I would like to question one aspect of this. It seems to me that a competent court worker carrying out exploratory interviews for the purposes of information giving and referral as described in the article would inevitably become involved in some short-term rendering of casework service. For some couples skilled and sensitive short-term service at that point can be more reasonable than at any later point. The reality of the new circumstance created by the tentative embarkation on court proceedings may help such short-term service to produce a change of direction and positive results.

Perhaps the distinction is primarily between such "on location" short-term counseling and long-term marriage counseling. If we assume that such short-term counseling service will be carried on within the court framework, it would be primarily the longer-term marriage-counseling cases which would be referred to the community services. In my judgment the demand for skill is equally great in both kinds of service.

How marriage-counseling services in the community outside the court can be more effective in stemming the development of broken marriages is a critical question with multiple answers. Improved and more productive working relationships between individual lawyers and community-service agencies engaged in marriage counseling could result in a more substantial direct referral flow between them. Such a flow of cases at a stage when the client is first thinking about divorce and considering court action might be even more productive than at the later date of court contact. A national committee on lawyer-family agency cooperation is currently at work under the Family Service Association of America to promote more effective collaboration.

Perry B. Hall
Executive Secretary, Family and Children's Service, Pittsburgh

Counseling outside the court

There has been a paucity of source material concerning the operation of the integrated court for all justiciable family problems—usually referred to as a family court. Little authoritative writing has appeared on the effective utilization of social services in the court process in matrimonial actions—divorce, separation, and annulment. Therefore, the article by Sheridan and Brewer represents an important and useful contribution to this field.

The authors point out that specialized social services may make a contribution to the handling of divorce cases in two ways: social studies to guide the court's decision as to custody, visitation, and alimony and in the provision of marriage counseling; but they conclude that marriage counseling should be a general community service separate from the court.

The concept of a separate agency for marriage counseling has been adopted in Baton Rouge after careful study by the family-court advisory committee. The Family Counseling Service operates outside the court as a private community agency. From experience since the counseling service was first inaugurated on October 1, 1956, it seems that the organizational plan was a wise one.

Joe W. Sanders
Judge, The Family Court, Baton Rouge, La.

SODDY: *The nursery school's role*

In his interesting article on "Adjustment to School Entry," (CHILDREN, January–February 1957) Dr. Kenneth Soddy arrives at three psychological criteria for judging a child's readiness to take on school experience. A similar search for psychological rather than chronological criteria for school entrance has been going on for some time in the nursery-school movement, since nursery schools are not part of the compulsory-education system. It is surprising that Dr. Soddy bypasses this subject altogether.

I think most nursery-school educators would readily accept his criterion of "a sufficient degree of emancipation from the exclusive tie of mother love to be able to transfer part of his dependent relationship onto other adults." They might well take the position, however, that the other criteria of "ability to tolerate not being the sole center of love in the family" and "ability to enter contemporary child society on a basis of equality" represent growth processes most successfully accomplished when the child is gradually inducted into a life of his own, away from the confined orbit of family life.

Part of the function of nursery school is to give the child a chance to taste the sweets of human relations that lie beyond the horizon of family relations

and at the same time to lead him gently through the conflicts he experiences in trying to absorb the social mores of give and take. I am not questioning Dr. Soddy's criteria, but am asking what the optimal opportunities are, at home and outside the home, which should be offered to young children to help them achieve this readiness by the time society expects them to attend "regular" school.

Dr. Soddy defines, very usefully, the kinds of behavior that signify danger for the future development of the child. Most thoughtful teachers will feel at home with these distinctions, theoretically and practically, with one exception—the child described as the "inhibited extrovert." I doubt whether even Dr. Soddy's clear description of the paradoxical aspects of such a child's behavior will make the child seem any less a paradox or save him from being typed as "lazy." For the discernment required for identifying such a child the schools need ancillary services from the psychological and psychiatric professions.

Dr. Soddy points out that if the adults in the family regard their work lives negatively the child cannot be expected to look forward to school attendance. This observation should serve as a warning against glib generalizations about the sinister effects on children of having mothers who work. To a degree at least, these effects of a mother's working outside the home stem not so much from the fact that she works as from the meaning that her work has for her. However, no matter how positive a child's expectations of school may be it still behooves the school people to make his school life vitally interesting to him when he gets there.

While Dr. Soddy maintains that how a child adjusts to school reflects the basic qualities of the mother-child relationship, he also points out that the school is able to help many children achieve emotional maturity by providing them with opportunities for additional patterns of love, hate, dependence, and competitiveness with persons not involved in his family's emotional relationships. However, where early infancy and the preschool years have been characterized by serious deprivations or developmental failures, the school cannot be expected to remedy the emotional trauma nor help the child to learn in spite of it. In these instances, as Dr. Soddy makes clear, the problem belongs to specialized mental-health agencies.

Barbara Biber
Director of Research, Bank Street College of Education, New York

What schools can't do

I agree with Dr. Soddy's premise that too many demands are made on the school to solve the emotional problems of children. The school is equipped to deal effectively with the lesser emotional problems through the help of the visiting teachers and the better-informed teachers and principals who have made a concerted effort to know more about the meaning of behavior.

Such members of the school staff have learned much about the individual differences of children in their capacity to learn and to relate themselves to other children and adults. They have learned enough to be aware that the more serious emotional problems and disturbances are not in their realm and require the services of social agencies and psychiatric clinics for children.

Hyman S. Lippman, M. D.
Saint Paul, Minn.

STUDT: *Successful communication*

Values derived from the project described by Elliot Studt ("An Experiment in Training Teachers for Corrections," CHILDREN, January–February 1957) should have an impact on corrections training for some time and in many various ways. First, this project carried out at the School of Social Welfare, University of California, Berkeley, provided a contrast to what has happened so often in the past when practitioners and administrators from the field of corrections met with educators from the graduate schools of social work. Such meetings in the past have often been for only a part of the day, or 2 days at the most. Too often each group left with feelings of frustration because they could not make the other group understand their problems. Yet both knew they wanted the same result—more trained people for work in corrections, especially probation and parole. Why then this feeling of frustration?

A phrase contains the answer: Lack of communication. Mrs. Studt has indicated that this was a major problem at the summer session. But the group at Berkeley had one advantage: Time—6 weeks. So the problem could be recognized by everyone; then definite attempts made to attack it and positive results achieved. If nothing else had occurred, this alone would have made the project worthwhile.

Mrs. Studt has also mentioned another result—the pool of potential educators which has been developed among correctional workers. Graduate schools of social work seeking faculty must recognize that most of the practitioners who participated in this project are young, that they have not as yet risen high among the ranks of the supervisors and administrators. But if these people are not recruited soon into full-time teaching positions, they may be lost to the graduate schools. These practitioners are likely to advance and to be reluctant to leave practice for education because of salary differentials between administration and education. The caliber of the practitioners who were selected as students is reflected by the three that have accepted new positions of greater responsibility since last summer.

Lastly, and not mentioned directly in the article, is the fact that for the first time there is a list on a nationwide basis of practitioners in corrections who have the necessary academic training for a faculty position, who have experience in corrections, and who are interested in teaching. This list includes those practitioners who were nominated and made application but who could not be included as students because of space and financial limitations on the project, as well as those who were accepted.

John A. Wallace
Executive Assistant, National Probation and Parole Association

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U. S. GOVERNMENT PRINTING OFFICE: 1957

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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JUVENILE COURT STATISTICS 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 37. 1956. 21 pp. Single copies available from the Bureau without charge.

This report shows that 1955 was the seventh consecutive year of increase in juvenile-court delinquency cases. The increase over 1954 was 9 percent and the overall increase since 1948, 70 percent. In 1955 roughly 2 percent of the children aged 10 through 17 in the United States were involved in delinquency cases. Boys' cases outnumbered girls' 5 to 1.

EDUCATIONAL LEAVE IN PUBLIC CHILD WELFARE PROGRAMS: a way to better services for children. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Child Welfare Reports No. 6. 1957. 13 pp. Single copies available from the Bureau without charge.

Notes that the major method of achieving skilled welfare services for children is to obtain competent personnel through providing professional training for agency staff; describes the 20-year history of granting educational leave to workers on staffs of public welfare agencies and providing them with the necessary training; lists difficulties encountered in carrying out this educational-leave program; presents a table showing the number of States granting educational leave each year from 1937 to 1955, the amounts budgeted by each State for this purpose, and the number of workers for whose training the funds were budgeted.

SELECTED CHILD WELFARE EXPENDITURES OF STATE AND LOCAL PUBLIC WELFARE AGENCIES, 1954-55. Children's Bureau Statistical Series No. 36. 1956. 26 pp. Single copies available from the Children's Bureau without charge.

The data reported in this publication show that State and local public welfare agencies spent an estimated $135 million for child-welfare services during the year ended June 30, 1955, a rise of one-fifth since 1952, the first year for which such figures were published. About $75.5 million, or 56 percent of the total 1955 expenditures, were State funds; $25 million, or 39 percent, local; and $7 million, or 5 percent, Federal.

Figures for the year ended June 30, 1954, are also included.

MEETING FAMILY NEED THROUGH HOMEMAKER SERVICE. Mildred Arnold. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 13 pp. Single copies available from the Bureau without charge.

Presented at the annual meeting of the National Committee on Homemaker Service in 1956 at Cleveland, this paper discusses the functions of homemaker services against a background picture of today's changing patterns of family life and the changing concepts of social service.

INSTITUTIONS SERVING DELINQUENT CHILDREN: Guides and Goals. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication 360. 1957. 119 pp. 40 cents. (Available about May 15, 1957.)

Successor to "Tentative Standards for Training Schools" (CB Pub. 351, 1954), this publication discusses the philosophy and administration of institutions for delinquent children; the physical plant; and the institutional treatment program, including preparation for the child's return to the community and the aftercare services.

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JULY • AUGUST 1957

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Hungarian Resettlement

How Children Cope

Helping Adoptive Parents

Finding Disturbed Children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

VOLUME 4
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A ship's crewman helping to assemble Hungarian children and baggage for a landing in New York harbor. Most of the 32,000 Hungarian refugees who arrived in this country between mid-November and May 1 (see pp. 123–131) came on United States military ships and planes or on facilities chartered by the Intergovernmental Committee for European Migration. Formed in 1952 to transport refugees and migrants, en route to lands of resettlement, ICEM is financed by 27 member governments.

◀ *the authors*

In an article in the November-December issue of CHILDREN, Lois Barclay Murphy discussed some of the stresses on children today. In this issue she brings evidence from her studies at the Menninger Foundation of how children call on their own inner resources to meet the problems of living. A full report of these coping studies will soon be published by the Foundation. Dr. Murphy is the author of "Personality in Young Children," Basic Books, 1956.

Group work, administration, casework have all occupied Jules Schrager at various times in his social work career. Before taking his present position he was chief residential worker in the department of child psychiatry at the Menninger Foundation. A graduate of the Graduate School of Social Work, Adelphi College, he has for the past 2 years been a student in the psychoanalytic child care program at the Institute for Psychoanalysis in Chicago.

A psychiatric social worker by training, Betty Woodward has had considerable experience in placing older children and sibling groups, as well as infants, in adoption. Prior to going to Hope Cottage, which provides services to unmarried mothers and their babies, including adoption, she was on the staff of the Presbyterian Child Placement Service for Texas. Previously she was consultant on adoption and foster care for the Texas welfare department.

Collaborating with Eli M. Bower in the study he describes were two other staff members of the California State Department of Education: Peter Tashnovian, consultant in educational research, and Carl Larson, specialist in teacher education. With the department since 1950, Dr. Bower received his doctorate from Stanford University in 1954. In the past 2 years he has been serving as special consultant for the National Institute of Mental Health.

Three years ago Aurora Romero spent 4 months in this country observing social work services to children as a United Nations Fellow from the Philippines. A graduate in education from Arellano University, she has worked in her country both in public welfare and in the public schools where her focus has been on counseling children and their families. She plans to return to this country soon to study.

Two years ago in its special number commemorating the 20th anniversary of the Social Security Act, CHILDREN carried an article by Norris Class entitled, "Public Policy and Child Welfare." That he has continued his thinking about child welfare administration has been attested by a recent series of articles in *Child Welfare*, journal of the Child Welfare League of America. Mr. Class organized and administered the State child welfare program in Oregon.

Over 30,000 Hungarians came to American communities between mid-November and May . . .

SPEED IN RESETTLEMENT—HOW HAS IT WORKED?

KATHRYN CLOSE

THE FASTEST mass immigration this country has experienced since the passage of restrictive immigration laws in 1922 began last November. On November 4, the revolution in Hungary went down to defeat and thousands upon thousands of Hungarians began to pour across the Austrian border. Less than 3 weeks later, on November 23, the first of these escapees reached the Joyce Kilmer Reception Center in New Brunswick, N. J. Over 30,000 of their fellow-countrymen followed them in the next 5 months. Two-thirds of them were under 30, and nearly a third between the ages of 15 and 19. Of the latter a large portion were unaccompanied by an adult. This was especially true of the 19-year-olds, but it was also true of some 800 to 1,000 adolescents under 18. Of the 5,300 children under 15, all but a scattered few 13- and 14-year-olds were with at least one parent.

Few of the refugees stayed within the Kilmer Reception Center more than 2 or 3 weeks; most of them were on their way to communities of final resettlement within 10 days.

The wheels of refugee resettlement have turned in this country almost unceasingly since the early days of the Hitler persecutions in Germany in the 1930's, but always they have turned slowly. Only once before—when the people of this country opened their hearts and homes to British children threatened by the Nazi blitzkrieg—has a wave of national concern and enthusiasm turned them to anything like the speed with which they have spun in recent months. Later efforts to bring Spanish and Jewish children from Vichy France to escape the Nazis became so snarled in red tape that only a few children managed to get here before the Nazis slammed the doors to escape. During our own direct embroilment in the war the flow of refugees all but ceased.

After the war, because of the quota restrictions of our immigration laws, our gates were closed to all but a few of the hundreds of thousands of persons left homeless in Europe because of the wartime and postwar upheavals. They were opened slightly by the Displaced Persons Act of 1948 and its ensuing amendments, allowing limited numbers of such persons to enter on quotas mortgaged against future immigration, and by the Refugee Relief Act of 1953, providing for a limited number of nonquota visas to be issued to specified groups of people, including escapees from Communist countries.

Through all this our country has developed a pattern. The Federal Government opens the gates (with congressional direction as to how wide) and lays down the conditions for entering. Voluntary welfare agencies, accredited by the Government for the purpose, help to select those who are to come and see that they get here and find a place in a community. For the refugee awaiting entry the system has been agonizingly slow; but for the agency bringing him in it has allowed plenty of time for preparation of his resettlement into a community on this side. Where unaccompanied children and young people are concerned, it has allowed the agency to find out through workers overseas something about the youngster which could be used as a guide to placement plans.

Because of the nationwide response to the Hungarians' plight and the necessity for speed in relieving Austria of at least part of the refugee burden,

the Hungarian program has been markedly different from previous refugee programs in these ways:

1. The United States doors were open to the Hungarians, at least temporarily, after careful security screening, regardless of their health conditions.

2. Except for the first 6,500 who received the last of the unused nonquota visas for escapees under the Refugee Relief Act, the Hungarian refugees arrived without "green cards," or permanent visas. Their "white cards" have admitted them only as parolees—a status made possible by a section of the Immigration and Nationality Act which gives the Attorney General authority to "parole [any alien] into the United States temporarily . . . for emergent reasons or reasons deemed strictly in the public interest."[1]

3. The voluntary agencies were *asked* by the Government to resettle the refugees and even, at first, to select and apportion among themselves those who were to come.

4. Until May 1 of this year, when the Hungarian influx had slowed to a trickle, all incoming Hungarian refugees were brought to one central reception center, the Army's Camp Kilmer, known during the program as the Joyce Kilmer Reception Center.

5. The sponsoring agencies were given neither the time nor the information to make individual resettlement arrangements with their contacts in local communities before the refugees' arrival.

6. While a Presidentially appointed committee, the President's Committee for Hungarian Refugee Relief, offered coordinating and expediting services to the sponsoring agencies, no standards of placement were required or recommended by the Federal Government for the foster-home placement of unaccompanied minors.

7. Federal funds were made available: for housing, feeding, and providing emergency medical service to the refugees on their arrival at the reception center and for their transportation to communities of resettlement (by the International Cooperation Administration); and for the hospitalization of those found to be medically excludable, especially the tuberculous (by the ICA through the Immigration and Naturalization Service).

Persons who have worked in refugee programs in the displaced persons camps of Europe have often despaired at the snail-paced resettlement machinery, as they have watched once-proud people lose their self-confidence and deteriorate into dependency. Last winter suddenly they found that a human and political emergency was spinning the wheels faster than they could have ever dreamed—for one group. And they faced new questions: does speedy resettlement also have its hazards for people, and if so how are the new refugees, especially the children and young people, being protected from them?

With these questions in mind I visited Camp Kilmer and some of the communities where young Hungarians have been sent for resettlement. The visits were too limited to produce any definite answers. But they revealed some of the problems that agencies, workers, and refugees have faced in this latest resettlement program.

AT THE RECEPTION CENTER

At Kilmer seven voluntary sponsoring agencies were helping refugees to find their way to jobs and homes in American communities. Operating separately and independently, they enacted their roles of resettlement expediters from varying policies, amounts of experience, and degrees of pressure.

Five of these agencies were sponsoring the bulk of the refugees: the National Catholic Welfare Conference; the Church World Service, representing various Protestant churches; United Hias Service, the Jewish migration agency; the Lutheran Refugee Service; and the International Rescue Committee, a nonsectarian organization. The four religious agencies alone handled 29,600 of the 31,900 refugees who had come to the camp by the end of April.

At the moment in Austria when a refugee indicated a desire to come to the United States, he had been asked his religion and then usually steered toward the corresponding religious agency. If he somehow got to this country without an agency sponsor, the designation was made on his arrival at Kilmer, often on the same basis. Those who came through the International Rescue Committee or the two other nonsectarian sponsoring agencies—the Tolstoy Foundation and the United Ukrainian Relief Association—were for the most part sought out by those agencies in the camps of Austria. The IRC was especially on the lookout for students and professional persons. It also sponsored persons who preferred the service of a nonsectarian agency.

Kilmer while the Hungarians were there might have been likened to a glorified Ellis Island—"glorified," in spite of the mud and barrenness, through the facilities available and the general air of welcome. The Army had provided good food, clean

barracks, a hospital, well-equipped recreation rooms, and an abundance of Hungarian-speaking personnel. At the peak of the influx of refugees, several Government agencies and 11 voluntary agencies other than the sponsoring agencies had offices in the camp to provide various types of services—employment classification, scholarships for students, placement interviews for scientists or other highly trained persons, English classes, orientation-to-America courses, clothing, telephone calls to relatives.

Thousands of offers of jobs and homes poured into the agencies—most of them valid, though some of them obviously exploitative. People from the surrounding area flocked to the camp to take refugees out to dinner or invite them into their homes—though the practice was discouraged by the agencies. Some came from farther away with job offers and immediate transportation to the community. While direct recruiting in the camp was generally not allowed, frequent exceptions were made when credentials could be produced.

The purpose of the Reception Center was twofold: to provide the refugee with a place to stay while he could be "processed"—that is, given supplementary security and health "screening" by the Government; and to give the sponsoring agency a chance to match the refugee's wishes and qualifications with the job and housing opportunities available in local communities. Because of the desire on everybody's part to keep Kilmer from becoming a DP camp fostering deterioration and dependency, decisions were reached with incredible speed. They were based mainly on job qualifications in instances of highly trained persons, but for others less skilled or whose skills were less in demand, the choice of where a refugee was sent was usually determined by where a person, agency, or committee existed who was willing to be his local sponsor—to make temporary living arrangements for him and to see that he obtained a job and a place to live, or in the case of an unaccompanied teen-ager, to find, and presumably supervise, a foster-family placement.

When, as frequently happened, the refugee had a relative in this country, the sponsoring agency usually verified the relative's willingness to accept him, and his wife and children if these were along, before sending him on. Only one agency made it a policy to inquire through a local social agency before sending an unaccompanied teen-ager on to his relative into the quality of care the latter could offer.

A newly arrived Hungarian couple and their son talk by phone from Kilmer, N. J., to the man's brother in another State. Free long-distance calls were one of the many services offered at the reception center by the American Red Cross.

Agency Procedures

Differences in the agencies' resettlement procedures stemmed mainly from two sources—differences in their own structure and in the sizes of the loads they carried. United Hias Service, with a tradition of carrying out all resettlement through local agencies staffed with professional social workers, sent all its refugees, except families or single adults going to relatives, to the care of Jewish family-service agencies. The agency follows this policy out of conviction that having been through great emotional crises, involving sudden separation from the loved and the familiar, and finding themselves confronted with a language and customs they do not understand, all refugees need help from persons skilled in understanding the effects of the emotions on decision making and adjustment. It applied this same theory at Kilmer where every Hias-sponsored refugee was interviewed at least once by a professional social worker.

Because of the Catholic diocesan structure, the National Catholic Welfare Conference could look to a diocesan resettlement agent, usually the clerical head of the Catholic Charities, to make plans to receive refugees and help them on their arrival. How much these agents use the professional social

workers who carry out the family and children's work within the Catholic Charities and how much they rely on the parish priests is their own decision.

At Kilmer, where the NCWC handled more than three times as many refugees as any other one agency, the agency found it impossible to provide social casework interviews to all its clients. After the first few weeks of operation, however, caseworkers were called in from the Catholic Relief Services, the child placement branch of the NCWC, to interview every unaccompanied minor under 18. Altogether about 700 unaccompanied youngsters under 18 came to Kilmer under NCWC sponsorship.

The Lutheran Refugee Service works through 32 area refugee committees, which in many instances are housed and administered through a statewide Lutheran welfare agency. These committees channel offers of jobs and hospitality to the national agency from local Lutheran congregations, clergymen, and sponsors, who in turn call on the local Lutheran service society for help in planning for receiving refugees, for counsel in meeting individual problems, and, occasionally, for direct casework service to refugees. At Kilmer, the Lutheran agency's activities were directed by a pastor with professional social-work training who when he spotted an unattached teen-ager or a serious personal or family problem would make arrangements for sending the refugee directly to the care of a professionally staffed service society. As a result of its careful screening out of unaccompanied teen-agers overseas, the agency received only 6 unaccompanied minors under 18 at Kilmer.

The Church World Service is the coordinating agency for the refugee work of over 30 Protestant and Eastern Orthodox denominations. At Kilmer, as in all previous resettlement work, Church World Service relied on the interest of local churches working through their various denominational councils. These churches can, and often do, call on existing community social agencies to help with individual refugee problems, but because of the looseness of its connection with them, the Church World Service has not been in a position to formulate local resettlement policy. Like the Lutheran agency, it made a conscious effort overseas to screen out youngsters under 18. Some did manage to reach its offices at Kilmer, however, and these, including at least a few boys under 16, were sent out to local communities for placement in family homes through the ministers of sponsoring churches.

The International Rescue Committee has in general even less tangible community connections. Except in the six localities where it had set up offices to carry on local resettlement activities directly, it worked through a local or State committee, sometimes communitywide in its representation, sometimes sponsored by a single organization such as a chamber of commerce. By the end of April the IRC had received about 150 unaccompanied minors, many of them students. The agency made direct placements through its own offices of the 23 who were under 18, putting most of them into families, but sending a few to private boarding schools which had offered scholarships.

The Tolstoy Foundation and the United Ukrainian-American Relief Commission, handling a total of less than 500 refugees, made their placements largely through interested nationality groups.

Keeping Families Intact

One common policy followed by all the Government and sponsoring agencies at Kilmer was to keep families together. This had also been the agencies' guiding principle in making selections overseas from the thousands of Hungarians in Austria who were applying for admission to this country. It was their reason for not selecting unaccompanied teen-agers for migration before the possibilities of reuniting them with their families could be explored. Nevertheless, because of the confusions of the flight from Hungary and the pressure of numbers on Austrian hospitality emigration-caused separations did occur.

To avoid further separations, the sponsoring agencies at Kilmer sent each family to a community as a unit whether or not all the employable members had qualifications in demand in that particular spot. If a college placement was made for a student who had arrived with members of his family, the agency looked for resettlement opportunities for the family near the college he would attend. The determination to keep families together was the chief reason behind the agencies' reluctance to let an IBM machine set up at Kilmer to match job offers with qualifications take over a major portion of the resettlement process through punchcard procedures.

The Immigration and Nationality Act requires the exclusion of persons having tuberculosis, mental illness, or dangerous contagious diseases. One threat to family cohesion arose from the exceptional nature of the program in admitting persons to this country under parole who had legally "excludable diseases." The United States Public Health Serv-

ice, cooperating with the Immigration and Naturalization Service and with the Department of the Army, performed reexaminations of all refugees within a day of their arrival at Kilmer to determine those who because of the danger of contagion needed to be hospitalized. To make it possible for the refugees with tuberculosis to have their families close at hand, the Public Health Service achieved agreements through the State health departments with a number of State and private sanatoria to accept refugee patients, for whom a daily fee would be paid by the Immigration and Naturalization Service. Thus a refugee woman, ill of tuberculosis, could be sent to a hospital in or near the community in which a job awaited her husband, or a man could be hospitalized near a community promising him a job opportunity on release. By the middle of April, some 400 persons had been so hospitalized for stays of 6 weeks or longer.

Student Program

At Kilmer prospective university students were referred, and if found academically acceptable, transferred to the World University Service. By the middle of May, WUS had interviewed, with the help of the sponsoring agencies, 1,300 prospective students for possible scholarship placement, accepting responsibility for 1,000. While only 275 of these could be placed immediately in colleges—language and credit transcript barriers being as much of a deterrent as an insufficiency of scholarship offers—the WUS sent the others either directly to a residential English-language program or to New York City where they lived in groups under the WUS or their sponsoring agency's care while awaiting language-school or college placement. Under the arrangements made by the Institute for International Education and financed by the Ford and Rockefeller Foundations, extensive English-language programs for Hungarians, taking a total of 130 students, were held on two college campuses. Later, 15 other colleges offered "package programs" for English-language study for 10 to 25 Hungarian students.

IN THE COMMUNITIES

Nothing like an exhaustive survey of how the Hungarians are faring in American communities could be possible at this early date for they are scattered from coast to coast. City-bred people for the most part, the great majority have gone to urban jobs in urban communities, although farm offers came into Kilmer in abundance. In my visits in early April to three communities—a large metropolitan area, a medium-sized city, and a smaller city—I could only gather hints as to how they were getting on.

There could be no doubt, however, about the warmhearted generosity of the thousands of American men and women who responded to the President's appeal to make way in their communities and even in their homes for persons who, while in a sense romantic heroes, were after all complete strangers, "foreign" in language and manners.

Employers had much to gain because these refugees brought with them many skills needed in this country. An occupational breakdown made by the United States Department of Labor shows that nearly three-fourths of those entering the labor force had been classified as professional workers, technicians, craftsmen, or operatives. But employers knew that the use of skills requires some effort on their part if the persons having them cannot communicate. One manufacturing company had taken 32 engineers and their families out of Kilmer, paid for their food and lodging until they received their first paychecks, and set up English classes which would occupy half their worktime. The company had also assigned to each newcomer a sponsor from among the older employees, part of whose duty was to see that his wife took a neighborly interest in the Hungarian's wife and family.

In a well-to-do suburb, I met with a "mothers' club" composed of about 15 young married women, each of whom had a 15- to 19-year-old Hungarian boy in her home. All of these women had small children of their own and none had a Hungarian background. Matching tales about their boys' heroic exploits as well as about their helpfulness around the house, they each expressed a determination to see that the boys finished high school or even college. They had seen to it that the local school board established an English class for Hungarians. They had also asked a social worker from an agency concerned with the foreign born to meet with them once a month to discuss ways of helping the boys.

The social worker was also giving counsel on a less formal basis to a number of other women, also not of Hungarian background, who had Hungarian teen-agers in their homes. These women had responded to their priests' appeals for help on a day when 23 boys, all under 17, arrived in town from Kilmer only 12 hours after the Catholic resettlement agent had received notice that 18 were coming.

While most of the teen-agers were placed with others, many members of the rather large Hungarian-speaking population of this community had taken in relatives or had been active in helping incoming refugee families to resettle.

The personal touch of welcome was also evident in the schools.

One first-grade teacher with 25 other children in her class was giving a 9-year-old Hungarian boy and his 6-year-old sister a half hour a day of individual attention. She had sat up nights making herself a Hungarian-English dictionary from words taught her by a friend so that she could communicate in some way with the children.

"All the children in the class are learning Hungarian from Ferenc," she said, "but I'm the only one he gets angry with for mispronouncing a word!"

Special English classes for adults were carried on in all three communities. In one, they were a part of a regular city system of evening and day classes for the foreign born. About 15 Hungarian teen-agers were attending the full-time day classes. One of the teachers had taken it upon herself to obtain after-school jobs for two of them.

Volunteer Effort

In another community university students were serving as volunteer teachers in an extensive English-language program geared to the personal needs of the learner. Three hundred students had placed themselves "on call" to give individual instruction at any one of three centers to whatever Hungarians happened to turn up at any time during the day.

The apparently inexhaustible efforts of many volunteers played a major role in settling the Hungarians in. In the smaller city a citizen's committee spent more time in doing than planning. It brought refugees to the community and *then* faced the problem of temporarily meeting their food and shelter bills and of finding them jobs and housing. But it *did* find them jobs and housing and furniture and clothes and it accomplished this through the individual efforts of the committee members themselves. They took refugees into their own homes, called prospective employers about jobs, acted as interpreters in employment interviews, looked for empty houses and apartments, and made personal radio appeals for furniture and clothing, collected and sorted the donations, and helped the refugees move the furniture into their homes.

Cutting across religious lines, this committee acted as local sponsor for refugees from all but one of the major sponsoring agencies at Kilmer. It made loans from a fund, raised to help the Hungarian revolution, to put the newcomers up temporarily in hotels and sparked the school board into setting up evening classes in English. While a few of the committee members burned out their interest—one man after receiving 15 calls at his office in 1 day on refugee "business" was warned by his boss that "too much is enough"—on the whole, they have kept up their efforts for the newcomers. They listen to troubles, secure doctors for the sick, and urge their churches to pick up hospital tabs.

Committees of different types exist in the other two communities. In one, the committee is actually statewide in coverage and is concerned chiefly with stimulating local communities to activity and furnishing them with pertinent information. However, its members carry on an enormous amount of direct service work—jobfinding, homefinding, and general troubleshooting.

In the large metropolitan area, the committee has been established on more formal community-organization lines, with representation from social agencies, church groups, the school board, and other interested groups. Its main efforts have been toward channeling inquiries and offers of help to appropriate agencies.

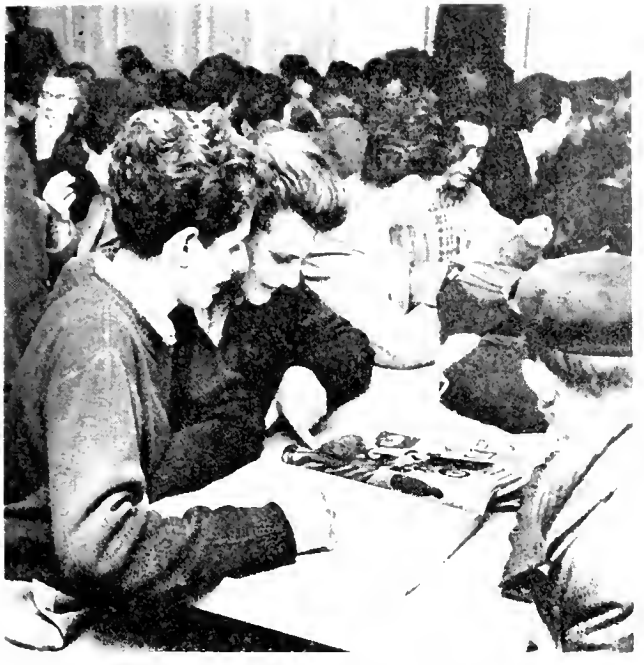
THE PROBLEMS

Along with all these evidences of good will, there were also evidences of problems.

One of the most serious can be illustrated by the story of 19-year-old Tibor. With a technical skill greatly in demand, Tibor was quickly placed in a job, and his pleasant manner made it easy to find him a motherly landlady. When after a month he lost the job, his sponsoring committee found him another almost immediately. Three weeks later Tibor was fired again as "impossible." He spent the following 2 weeks sitting around watching television until his landlady evicted him.

By this time most of the committee members were disgusted with Tibor, but one warm, Hungarian-speaking woman invited the boy to stay in her home. His first night there she sat up with him until 2 o'clock while he poured out his frustration and despair. He was in a state of agonizing indecision as to whether or not to return to Hungary, for he had learned that his father had been deported to Siberia and his mother was alone in Budapest.

While only 1 of the 3 communities had an appre-



Two teen-aged Hungarian boys, erstwhile freedom fighters, enjoy their first look at an American magazine. Many such boys are now learning the realities of American life in American foster families in various parts of the country.

ciable number of unattached Hungarian boys under 18, all 3 had received several 18- and 19-year-olds, including some girls. How many of these teen-agers were plagued with feelings of guilt and homesickness could only be surmised, for few knew enough English to talk to anyone freely. Even the sad-eyed Jewish 15-year-old who was the one youngster being supervised by a social agency had to communicate with his caseworker in broken German.

Many of the boys had been lionized on arriving in the community, but after the first splash of attention they were expected to adjust to life with a family of strangers whose language they did not understand, to live up to their regulations and demands, and often to exhibit gratitude. Most of the boys seemed to be getting along, but a few responded with such demands of their own that their hosts could no longer stand to have them around and either turned them back to the local sponsoring agency or on their own initiative found another family to take them in. Two boys who had been out of Kilmer less than 2 months had already been in three family homes each. Some of the adjustments were made difficult by the fact that a few families had thought they were taking a boy in temporarily only to find themselves "stuck" with him.

In all three communities some concerned people spoke of a cooling off of the community's enthusiasm. Some of them were troubled lest unfortunate individual incidents contribute to this. One committee, disturbed over reports of some raucous behavior among some Hungarian boys in a local bar, sent a volunteer, "a colonel in a full dress uniform," into the boys' homes to give them "a good dressing-down."

Worries and Uncertainties

Adding to the emotional strains of some of the refugees was worry about members of their families from whom they had become separated in the flight from Hungary. Some told of a brother or a father who had reached Austria ahead of them and had gone on to England or France as a first step to the United States, only to find that migration to this country was limited to Hungarians in Austria. Others had learned after arriving here that a member of their family has escaped into Yugoslavia. These people were inquiring at Red Cross chapters and other agencies about how to get their relatives to the United States. They were being told to tell the relative to apply to the nearest American consul for a visa under the regular quota system, although the Hungarian quota has been "mortgaged" for years to come. Current Government plans to allow relatives of refugees to enter this country as parolees, either from Austria or from a country of secondary refuge, were apparently not understood.

Sponsors and refugees alike were worried about the meaning of "parolee." Did it mean that any small slip would subject the refugee to immediate deportation? Would the immigration authorities be less lenient with parolees than with normal immigrants because sending them back would not require deportation proceedings? Would those whose "excludable diseases" did not heal not be allowed to stay? One social-agency head said he found it difficult to transfer his own conviction that this Government would not reverse its hospitality to refugees from a government under which arbitrary arrest and deportation were commonplace.

So concerned were the young women in the "mothers' club" over the uncertainties of the future for their young parolees that a number of them, only a few years older than the boys themselves, were seriously considering adopting the boys to give them status. Some were worried lest the boys be drafted and, by serving in the United States Army, lose their Hungarian citizenship without being given the privilege of American citizenship, thus becoming stateless. Although the selective service authorities in

Washington have ruled that parolees will not be required to register for the draft until their status as immigrants is made clear, in this community they were being advised that draft registration was a requirement.

Whose Responsibility?

Since this program included no requirement of individual assurances or affidavits of support, there is nothing through which legal responsibility might be attached to the local sponsor, though of course something of a moral obligation exists. While the national sponsoring agencies expect their local contacts to meet what problems arise, they have indicated their acceptance of "final responsibility" by coming to the rescue in instances of catastrophic medical costs or in some instances in which re-resettlement to another community has seemed advisable. However, how long such responsibility extends has not been clearly defined.

Some local sponsors were obviously unclear about how much responsibility they had taken on. A clergyman who had signed out about 75 refugees from Kilmer, for several churches, expressed uneasiness about whether this could ever lead to his being held personally to account for a financial obligation he could not meet. A woman telephoned a committee to ask whether she should notify the police that a 19-year-old Hungarian had left her home and his job to join his newly arrived father in another State. A man actually called the police to keep a Hungarian couple from leaving the hotel where he had given them jobs and maintenance.

Various degrees of responsibility had apparently been accepted by families who had taken teen-agers into their homes. Some, like the young women in the mothers' club, apparently regarded themselves as real stand-in parents ready to foot all bills that their young refugee's education and health might require. Others regarded themselves only as temporary "hosts" looking to the local agency or committee to meet extra expenses. Still others accepted a "moral obligation" but found themselves facing expenses outside their ability to pay. More than one family had taken a boy to the dentist and learned that it would cost at least $200 or $300 to put his teeth in shape.

Haunting the local agencies and committees was the specter of medical expenses. Many of the refugees were already well enough established in their jobs to pay for the mumps or measles or other occasional illnesses which happen in every family. But few had had time to save for emergencies, such as an operation, and some were using every spare penny to send food, clothing, and medicine back to their relatives in Hungary.

So far the costs of operations and other expensive medical care had been met in various ways. Doctors and hospitals were being generous with free service. In a few instances when a high, continuing expense was involved—as for a girl in the psychiatric ward of a voluntary hospital—the national sponsoring agency had agreed to pay the bill. Church congregations had responded to individual appeals. Generally a new arrangement had to be made in each case, for, except for the Jewish agencies, none of the local sponsoring organizations seemed to have an automatic plan for meeting medical needs. The sponsors in these communities were not calling on the public agencies for help for fear of putting the refugee into the category of "public charge," thus making him deportable under the immigration law. In any event, general assistance in the two States in which these communities were located was not available to nonresidents, nor in one to aliens.

Unaccompanied Minors

In none of the three communities I visited was any public authority inquiring into the protection of the minors brought into the State under this program. The State in which the large city is situated has a law governing the importation of unaccompanied minors, which sets up certain requirements including reporting, supervision, and the placement of a bond. However, the State welfare department was not even aware of the fact that at least 25 unaccompanied adolescents under 17 had been sent to that city, nor did their sponsors seem to be aware of the State's requirements.

The questions of whether and how to further a refugee's education were presenting some problems. Boys as young as 14 and 15 had been out of school 2 years working in industry. Their foster parents were eager for them to attend high school, but most of the boys wanted to get jobs in order "to buy a car." Here they ran up against State laws which require school attendance until the age of 16. On the other hand, some older boys wanted desperately to get an education.

One family took in two refugee boys, Sandor, aged 16, and Janos, aged 22. When Sandor was sent to high school, Janos quit his job in a bakery and said he wanted to go to school. The high school allowed him to enter, and at the time of my visit he

was still there studying hard, but 16-year-old Sandor had quit school and found a job.

Some of the older boys were hoping to receive university scholarships, to finish training already begun in Hungary. The community committee in the large metropolitan area was canvassing all colleges and universities in half the State for possible scholarship offers. It had secured a few but these were not in the fields of some of the most advanced students' interests. Nothing was available for a girl who had lacked only 4 months of graduating from the University of Budapest as an architectural engineer. There was a chance that some of these students would be placed by the World University Service in the fall, but so far this agency had only 300 fall scholarships pending for the 800 students on its waiting list.

Some Unknowns

In none of these communities did anyone know exactly how many refugees had arrived or how well everyone was adjusting. Among the unknown quantities were the refugees who had come to relatives. They became known only as crises arose, as when the aunt of a Hungarian boy called an agency for help in paying for an appendectomy. One sponsoring group went to the railroad station for some Hungarians and found itself with an extra family, stranded there by a man who had disclaimed relationship when he saw that the cousin he had come to meet had brought along his wife and five children.

In one community a nonsponsoring family service agency was giving casework service to the relatives of a refugee family in an effort to prevent an explosion of the tensions which had resulted from the doubling up of families. This agency's director pointed out that because of decentralization and inconsistency of services to the refugees in the community, no clear picture could be obtained of their adjustment. He suggested that many more of the Hungarian families might have used casework service if it had been made available to them.

There was some indication that the separation of services, and therefore of refugees, on a religious basis was bewildering to them. In one community the unaccompanied teen-agers sponsored by one religious group had been taken out of an English class run by the school board but located in the church house of another religious group. Later, in one of their class conversation practices, one of the remaining boys asked another: "What is the difference between a Lutheran and a Catholic in America?"

In no community did I encounter any participating person who felt that the resettlement program as a whole was failing. On the contrary, much faith was expressed in the contribution these newcomers would make to American life. To persons who had worked in other refugee programs the comparison between speed and the tempo with which refugees were formerly brought to this country left no doubt as to their preference for the quicker pace, in spite of some of the confusions it brings. (One sponsoring group learned 2 weeks after it had brought 50 refugees to town that one of the women had left her baby behind in Kilmer.)

"These refugees have come so fast they hardly know where they are," said one agency worker. "There hasn't been time for them to prepare for life in America nor even to digest their own decision to come. But neither has there been time for them to become psychologically pauperized by helpless waiting in DP camps. They still have their self-respect."

The speed of the program has also left the communities of resettlement with a few unsettled problems, some of which cannot be solved without outside help. The chief needs expressed were:

1. The dissemination to communities, by one coordinating agency, of information clarifying national policies in regard to the refugee, especially in reference to: the meaning of parolee status; current immigration procedures in regard to refugees still in Austria, Yugoslavia, or other parts of Europe; the definition of "a public charge" as it relates to deportability; the responsibility incurred in sponsorship; selective service regulations.
2. A nationwide educational program to keep alive the story of the Hungarians and spread understanding of the psychological strains these refugees, especially the unattached teen-agers, are undergoing.
3. Some help in meeting medical or other unforeseen expenses arising after resettlement.

Time alone can tell just what resettlement will mean for each of the Hungarians who has arrived here since last November. In the meantime it seems fair to observe that the world is made up of unpredictable human beings, including refugees, local sponsors, businessmen, churchmen, social workers, administrators, Government officials, generals, and Congressmen; that an unrippled coordination suitable to them all is perhaps an unachievable goal; and that the human spirit can be remarkably generous and tough.

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[1] Sec. 212 (d) (5), Immigration and Nationality Act, 1952, as amended.

LEARNING HOW CHILDREN COPE WITH PROBLEMS

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AMERICAN CHILDREN have been observed in longitudinal studies for some 30 years. To be sure, the numbers are relatively small: most of the children studied were children in cities or university centers, and often all too many of them came from faculty families who had placed them in university nursery schools or experimental schools. Such centers had the facilities for carrying out careful studies and the children in them were easily accessible. Thus the samples are not by any means representative of even the major subcultural groups in the United States.

Even so, these samples of middle-class, normal children have produced data to support some important conclusions. It is clear that whether children grow up in the San Francisco Bay area, in New Haven, Conn., or in suburbs of New York City, they have plenty of problems to cope with in the process. Some of these problems grow out of things that are done to or happen to the child: operations; accidents; childhood diseases and virus infections; the uprooting from friends and a familiar neighborhood as father gets a better job in another town or the family moves into a better house in a very different neighborhood; tensions bouncing onto the child from international relations, war anxieties, or actual absence of the father for military service; separations from parents who need to have a share of fun, recreation, and social life of their own or because of a need for hospitalization; separations when the child starts to nursery school or school, sometimes before he is emotionally ready to leave the home nest; tensions between parents, which are widespread and increase at time of ill health or stress in the larger family of in-laws.

Some of the problems arise chiefly within the child and arise from: discrepancies between the child's abilities and his goals; vulnerability or instability related to what may be rather minor inequalities or defects in the structural equipment of the child; anxieties and anger aroused by the arrival of a brother or sister, a competitor for the parents' affection; or feelings of being different from brothers and sisters or other children who may seem to receive more attention, love, or approval.

These problems and many others have to be considered as part of the *normal expectable sources of stress for children growing up in our culture.*

Different constellations of these and other normal expectable stresses, along with ups and downs in the stability of the organism during the shifting sequences of body development, contribute to the responses resembling behavior problems or "symptoms" commonly seen as children grow up. How these develop is beautifully documented in Jean Macfarlane's *A Developmental Study of the Behavior Problems in Normal Children Between 21 Months and 14 years.*[1]

All the time they are experiencing the normal stresses of life, children keep on growing, developing strength, and consolidating their resources until they become adults. Those rambunctious and difficult 4-year-olds, Robert in the movie, "*This Is Robert,*"[2] and Colin in our earlier studies,[3] have now turned into strong young men entering upon professional preparation along with many other erstwhile imps who created plenty of trouble and anxious days for mothers and teachers who had absorbed unrealistic concepts of "good adjustment" from set "norms." The trouble with such standards is that those who set them had not taken into account the question of how well adjusted it is *possible* to be under the conditions of growing up in our society. Sensitivities which contributed to "problems" when children were little have sometimes blossomed before our eyes into creativeness as these children matured with support and opportunities provided by school and family. Many a shy child—like Arthur who was timid in relationships with other children at the age of 3 and 4 but highest in scores on rhythm and

imagination, or Annina who made no contact with her nursery-school group until she got to a music hour after several weeks of sitting on the sideline—is now making a creative contribution to the community in which he lives through "little theater" work, teaching, or other activities.

Other children, like some of those described in some detail in Caplan's *Emotional Problems of Early Childhood*,[4] were able to come through in a well-integrated way when they were free from the pressures of their parents and were able to make decisions for themselves.

How Did They Manage?

Instances of this sort and many others which can be pulled out from the tightly packed files of research offices across the United States focus our curiosity on the question: What was going on? How did these children cope with their problems? What contributed to their increasing strength and ability to outgrow the behavioral difficulties and symptoms which they showed at various points during their developmental years? Such questions imply that the periods and levels of continuity and change during growth and their relation to the child's developing ways of coping with his environment, his problems, and his feelings present important areas for child study.

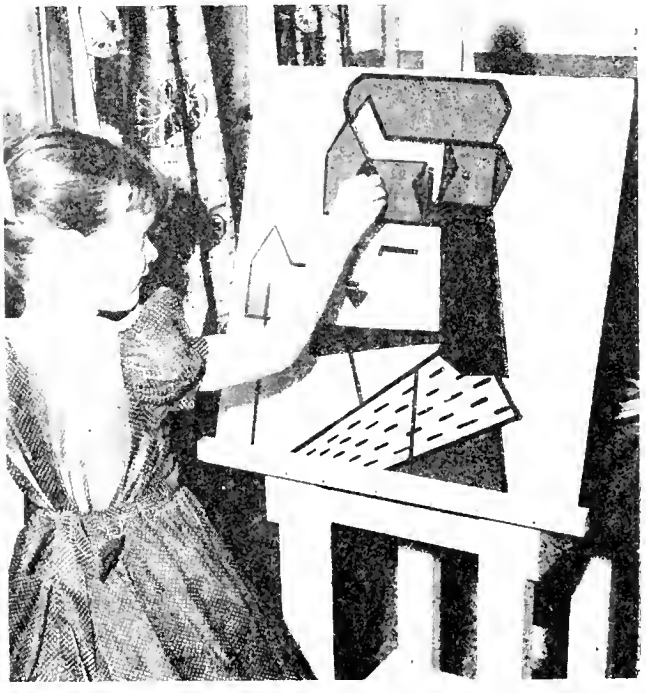
Biographers have been fairer than psychologists about the flux and change, the emergence and unfolding of personality, in spite of the strong tools provided psychologists by psychoanalysis, anthropology, and biology. Perhaps biographers have been freer because they are not burdened by biases and assumptions about the role of more or less statically conceived genetic factors or by standardized criteria of developmental norms. It is natural for them to think in terms of growth and struggle, of pressures and how the individual coped with them.

Along with biography we have in fiction a few extraordinarily discerning studies of children at different phases of development, as in *High Wind in Jamaica*,[5] *Early Sorrow*,[6] or *What Maisie Knew*.[7] Still these sensitive delineations of childhood experience do not tell us much about the efforts of the everyday child to deal with the everyday stresses of his life, much less the deeper levels of management of feelings aroused by the frustrations, deprivations, disappointments, and pressures of normal living.

With this dilemma in mind, in 1953 the Menninger Foundation, with the support of a grant from the Public Health Service of the United States Department of Health, Education, and Welfare, began to study a group of everyday children of preschool age. These children had already been studied during infancy by Drs. Mary Leitch and Sibylle Escalona so that we already had certain information about the families, the personality of their mothers, and the characteristics of each child. This made it possible for us to draw a line from the point during the preschool period at which we began studying, for a longer period of time, and with a greater variety of methods, a quarter of the children studied by Leitch and Escalona. This work is now being carried into the "latency" age (5 to 12), giving us a chance to see the children as they move away from their families into a wider world.

Our purpose was to focus on the child's range and ways of coping with everyday problems, the processes and sequences involved in development of new ways of coping with new problems as well as persistent and old ones, continuing styles of coping, and, if possible, relationships between the child's equipment (including temperament) and his style of coping and coping capacity. We included his

In taking an "embedded figure test" this little girl is helping observers to judge her ability to understand, master, and restructure—that is, to cope with—the environment. She is pulling out the house form from the picture of a king's head.



ways of handling impacts from events on the *outside* and also his feelings, conflicts and stresses from *within* himself.

It is not possible to describe here the total scope of the study. All we can do is to give a brief preview of some of the results we are organizing, some of which will be reported in a book on how normal children cope with their problems.

During their preschool period we saw these children coping with: separation from their mothers; new situations; the pressures and demands from male adult testers and examiners, as compared with the kinds of pressures presented by female adults; the threat of invasion of their privacy by an adult; authority pressures such as limits, demands to be quiet demands for compliance; competition from siblings; mother's pregnancy and the anticipation of a new baby; sex-role confusions; threat to body image and traumata of illness or an operation such as a tonsillectomy; aggression and competition from peers; special external events, such as the tornadoes that raged in Kansas in the spring of 1956; and anxieties aroused by the kidnaping and murder of a child in Kansas City during the early days of our study.

Styles of Coping

We cannot illustrate here the whole range of ways of coping with different experiences. We shall limit ourselves here to those observed in one sort of situation: the children as they took relatively standardized tests, both "structured" and "unstructured," intelligence and projective. We regarded these tests as challenges involving a mild degree of stress from failures, pressure for speed, and the like. As we observed the children coping with us and our demands, they taught us to watch for certain types of steps toward managing problems in the environment, such as:

1. Selection from the environment, narrowing the field, choosing what can be coped with; timing the sequences of coping or the period of adjustment to bring the stress within dimensions that can be handled.

2. Denial of reality; projecting; using fantasy to avoid the situation.

3. Resisting excessive or unwelcome demands; escaping from or evading them.

4. Tolerating; putting up with; accepting; understanding.

5. Mobilization of extra effort; compulsive repetitions or practice.

6. Cushioning; protecting self with available gratifications.

7. Compensating for; giving self leeway with momentary regressions; softening or embellishing the situation imaginatively.

8. Restructuring; reversing roles; controlling the adult or the situation; making it into something different which can be mastered.

Analysis of the intelligence-test behavior of the children of preschool age showed that most of the happiest or best adjusted children used a wide variety of defenses in a flexible way.

We are also finding it important to watch *sequences* of coping constellations, including defense mechanisms and direct efforts characteristic of successive age levels and of different personalities. Some children grow step by step; others take more uneven paths.

It is not possible to describe here all the different *styles of coping* which we have encountered, much less details of the factors which contribute to them. Finding out about the latter has required the most delicate study of infancy data in relation to later records and of the continuities and new developments in family dynamics over the whole period. We can, however, indicate certain major differences in styles.

For instance, certain children are much more apt to cope with the problems in the external environment by trying to change reality to suit their own taste. They might be called reality-changing copers. These children think up tests for the tester, thus reversing roles, suggest new ways of doing things, or utilize resources of the room not included in the test. It is perhaps not surprising to find such an approach among youngsters in Kansas where the environment actually was drastically changed in the last hundred years by the efforts of the settlers and later inhabitants. Other children develop coping methods which remain within the limits of reality as presented to the child.

Such differences do not seem to be related to intelligence in any close way. Among normal children within the age range we find both styles of coping at different intelligence levels, from average to very superior. While intelligence may be a necessary factor in the tendency to cope by reality changing, apparently it is not a sufficient factor. Possibly, aspects of native equipment or constitutional factors may be important here.

We could suggest a hypothesis that fantasy, even if not different in degree, serves a different purpose among children. Some use it to compensate for frus-

tration and others use it more to rehearse and develop creative ideas to be directed outwardly.

Creativity in coping will probably be found to involve different constellations of factors, such as:

1. Range of observation.

2. Discrimination in observation (unusual details).

3. Range of freedom to explore, manipulate, experiment.

4. Range of techniques with people.

5. Wide affective-cognitive range (ability to use and shift between secondary and primary processes and shades in between).

6. Freedom from excessive dependence on *assumed* limits or demands.

7. Large number of ideas.

8. Originality of ideas.

9. Constructiveness with materials (tendency to combine, integrate).

10. Capacity to integrate fantasy and impulses from within with opportunities in the external situation.

While the basic direction of coping efforts, such as the tendency to be *active* in coping with stress, may tend to characterize a child over the whole period during which we have watched him, dramatic developmental changes and sequences in the use of specific coping devices occur.

Sequences in Coping

Records kept for us by a mother show stages in her child's development of more mature methods of coping with fear, pain, shyness, dependence, competition from a younger sibling, and the like. These records also show successive stages in the evolution of the child's practice of gaining comfort from toys and animals. Beginning with a "cradle gym" and proceeding to stuffed animals and then to live cats, he used the objects first as sleep comforters, then as props against fatigue, and finally as companions to help him cope with the strange new situation of school.

A brief summary of the stages a little girl, Molly, went through in coping with fear of thunder and the noise of a jetplane follows:

1. As a 2-year-old Molly cried many times and was completely terrified during thunderstorms or when a jetplane passed overhead.

2. At 3 years 3 months, she got into bed with her older sister during a thunderstorm and accepted comfort from her.

3. At about the same time Molly began to reassure herself (and her baby brother) saying, "It's just noise and it really won't hurt you a bit."

At a party for the children in the study this child coped with her shyness by comforting herself with two large dolls.

4. A month later Molly was again terrified as a jetplane flew unusually low overhead; she cried, and clung to her sister for comfort. A few hours later she repeated several times to herself, "Thunder really doesn't hurt you; it just sounds noisy. I'm not scared of planes, just thunder."

5. The next month she opened the door into her parents' room during a thunderstorm, saying that her younger brother was afraid (although he was really fast asleep).

6. Nine months later, at 4 years 2 months, she was awakened from a nap during a thunderstorm, but remained quietly in bed. Afterward she said to her sister, "There was lots of thunder, but I just snuggled in my bed and didn't cry a bit."

7. Four months later, at 4½ years, Molly showed no fear herself during a storm and comforted her frightened little brother, saying, "I remember when I was a little baby and I was scared of thunder and I used to cry and cry every time it thundered."

Here we see the two-steps-forward-one-step-backward process:

1. *Over expression of fearful affect* and helplessness.

2. to *actively seeking comfort* from a supporting person.

3. to *internalizing the comfort* and the image of the comforting person, acting as comforter to herself.

4. to *differentiating sources* of the fear while still reverting to the need for physical comfort from her sister.

5. to *projecting the fear* to her baby brother (as a way of rationalizing getting the support she needed) and *seeking a*

symbol of support (opening the door without demand for physical or other active comforting).

6. to combining actively comforting herself with formulation of a *self-image* in terms of *pride in control* and mastery of her fear.

7. to *reaction formation*, achievement of bravery and referral of the fear to her past.

Problem Behavior

As in other longitudinal investigations of normal samples we are finding plenty of "problems," in the traditional clinical sense, in this sample of preschool children. What we are also finding is the place of so-called problems of behavior in the child's developing effort to deal with the stress and pressures of life. Thus Molly's screams, when she is terrified by thunder, bring mother's comforting response, physical and verbal (not scolding or admonitions not to cry), which she accepts, internalizes, and subsequently offers to her frightened little brother. We can thus see the *process by which the reinforcement of ego strength via specific successful coping efforts: (a) diminishes anxiety; (b) relaxes certain defenses; (c) substitutes other defenses and a more flexible use of them; and (d) leads to new coping efforts of a more socially acceptable or even creative type.*

The reader can easily see that many of the patterns which are ordinarily called problem behavior or even symptoms of emotional disturbance appear along the way among children's coping devices. We are not interested in moralizing about these or regarding them as deviations from ideal behavior or the kind of behavior that society prefers. We are more interested in the circumstances in which this behavior occurs, the role it has in the child's learning to handle his problems, the fate of it as the child loses or gains ground in developing appropriate ways of handling his problems, and the relation of individual styles of coping to the total development and maturing equipment of the child.

We find that it is typical for preschool children to show regressive types of behavior during intelligence tests. In fact in our sample of children the preschool period is characterized by a flexible use of a large variety of defense mechanisms. One of the main characteristics of development into the latency period in this group appears to be a narrowing of the range of defenses used by each child and the crystallizing of these into more rigid patterns of character structure. It will be important to watch whether the children who cope most comfortably with the widest range of typical life problems during the latency period are those who retain some of their flexibility to call on a variety of defenses, or are those who develop firmer character structure. If the latter is the case, this might mean that these children have a sharper awareness of self as distinct from the environment and therefore an ability to differentiate themselves from the confusions and pressures of the environment.

There are, of course, many technical problems of use of methods, the development of concepts, and evaluation of data. Our intention here has been only to offer a brief glimpse of the areas being explored in our efforts to learn what a child's coping behavior means to the child himself, and what it contributes to the development of his personality.

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[1] Macfarlane, Jean; Allen, Lucile; Honzik, Marjorie P.: A developmental study of the behavior problems of normal children between 21 months and 14 years. Berkeley and Los Angeles: University of California Press, 1954.

[2] This is Robert. New York: New York University Film Library.

[3] Murphy, Lois B.: Personality in young children. Vol. 2, Colin, a normal child. New York: Basic Books, 1956.

[4] Caplan, Gerald (editor): Emotional problems of early childhood. New York: Basic Books, 1955.

[5] Hughes, Richard A. W.: High wind in Jamaica. New York: Harper & Bros., 1930.

[6] Mann, T.: Early sorrow. New York: Alfred A. Knopf, 1930.

[7] James, Henry: What Maisie knew. New York: Scribner, 1906.

. . . every time we creep behind a technique or professional attitude there is the danger that we are trying to get people away from us a little farther, so that we can manage them in a more at-arm's-length kind of way.

Benjamin Spock, M. D., In Child Welfare, *May 1956.*

AFTER ADOPTION

I. AN AGENCY-SPONSORED PROGRAM

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THE ASSOCIATION for Family Living, a voluntary agency, offers a twofold program of service in the Chicago area: (1) an individual counseling service; (2) a service oriented around the concept of "family life education." In connection with the latter it provides professional leadership to many different kinds of groups: child-study clubs; PTA's; neighborhood parent organizations; and groups formed under the aegis of the association. From time to time, out of its concern over some special problem, the agency will announce a special series of discussions and will encourage participation from the community at large as well as from its membership. Accordingly, about a year ago the association announced that it was sponsoring a conference for parents of adopted children. Over 100 such parents attended the opening orientation session. Of these, 30 couples requested additional meetings. Two series of three sessions were arranged to run simultaneously, each series involving a group of 15 couples. Attendance at these series was uniformly high for both fathers and mothers.

This brief report is based on the observations of one of these groups. The facts about the participants were derived from a questionnaire filled out by the 30 parents in the same group.

The participants were middle-income people living in the Chicago area. Most of them were Jewish in religious affiliation and all were American born. The average age was 33.3 years. The majority had had at least a high-school education and a number were college educated.

Of the 17 children who were adopted by these 15 couples, 12 had been received before they were 2 months old, with the greatest number being under a week old at the time of acceptance. Only one of the couples had adopted "older" children: this couple had made a dual adoption, through an agency, of a brother and sister, ages 6 and 7, respectively.

At the time of the meetings the children ranged in age from 1 year through 11 years of age. Sixty percent were in the age range 8–11, the remainder in the 1–5-year group. The majority of children in each group were near the top of each age group.

Of the 17 children, 10 had been secured for adoption through physicians, and 1 through lawyers. The remaining 3 had been secured through social agencies. Thirteen of the 15 couples reported that they had had no professional help prior to, during, or after the adoption, aside from incidental legal services. The 3 couples who were agency clients (accounting for 4 children) had been interviewed frequently by a caseworker during the adoptive study, and monthly during the period of "supervision" after placement, as required by law.

General Observations

This paper will address itself to two main questions: (1) what accounts for the large response to this offer of service? (2) how does the content of the meetings reflect the concerns and interests of the adoptive parents? Tentative explanations only will be offered as suggestive of further exploration, as the limited size of the group and the informal, exploratory character of the program could provide clues only to the answers.

Since the program was limited to 3 sessions of 1½ hours each, it provided little opportunity for

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real relationships to develop, either between participants and leader, or between members of the group. This relative anonymity seemed at first to constrict the group's activity, especially in the early part of the first session. However, a fair amount of give and take occurred between members of the group and the leader. The initial resistance broke down when the leader abandoned the "lecture" type of approach and turned pieces of the discussion over to the group for elaboration. Encouraged by the leader's permissive attitude, and pressed from within by the urgency of the questions they needed to articulate, the participants began to lift the "anonymous" veil from their contributions and to express directly their personal opinions and concerns.

The content of the leader's presentation at each meeting consisted of brief opening remarks related to general problems of child development. These were purposely offered within the framework of the parent-child relationship as such, without reference to the special conditions surrounding adoption. Irrespective of the nature of these introductory comments, the participants, in "taking over" the discussion, turned the content into channels which were closer to their own areas of concern. Thus, no matter what subject had been introduced they connected it with the adoptive status of the child. Whether the problem was a universal one involving all children, or one characteristic only of one specific child, a special undercurrent of feeling seemed to differentiate the discussion of these participants from the discussions of other parents dealing with similar material.

According to scientific observations, emotional preparation for parenthood is not a full-blown characteristic of adulthood. Rather, it is a development parallel with the intrauterine growth of the child. Both the newborn child and his parents have had 9 months in which to get used to the ideas of the shifts which are taking place in their emotional interrelationships, and to learn to accommodate themselves to these new facts of life.[1]

Obviously this opportunity does not exist for adoptive parents. On the contrary, their problem is doubly complicated. They must experience troubled feelings derived from the fact that natural parenthood has been denied them.[2] The adoptive mother has also been denied the normal psychobiological processes which prepare a woman for motherhood. It is no wonder that in a parent-education group such couples become preoccupied with the fact of adoption, and tend to confuse stages in the developmental process of the child with the "specialness" characteristic of the adoption process.[3] Some of their observations in the discussion groups betrayed the deeper feelings with which some adoptive parents must struggle in developing strong ties of identification with their children.

Some Major Concerns

As the group's participation in the discussion increased, two major foci dominated. The first in importance (as measured by time given to it by the group) concerned *separation experiences* in the broad meaning of this term. The earliest developmental aspect which elicited noticeable anxiety was walking. Considerable time was devoted to discussion of optimal and average ages at which the young child can be expected to walk, and strong feelings of concern were expressed as to the effects of premature efforts to teach the child to walk. Some of the participants' observations on individual children were colored by speculations as to the *endowment* of the child and its relationship to early or late walking.

In attempting to understand these concerns, one can fall back briefly on similar observations noted with "natural" parents. Surely, the achievement of walking represents a high spot in the child's early development. One need only to see the wonderment and pleasure all parents express at the child's first step to be convinced of this. However, it seemed to this observer that something additional was being expressed by this group, which was perhaps derived from the impending change in proximity of child to parent.

With mastery over the means of locomotion, the child for the first time is able at will to utilize distance in his relationship to his parent. He now has a clearer means of expressing wanting to be close to the parent or wanting to be away from him. While this introduces a sharper concern for the child's safety to all parents, the anxiety expressed over it by the adoptive parents in their discussion seemed to imply some special implication. Perhaps, for them, movement away has some connotation of rejection of the parent by the child.

Moreover, since the participants referred so frequently to endowment in connection with walking, and since endowment is something that can only be evaluated properly as it unfolds, uncertainty in this respect was doubtless another source of their anxiety about when walking might occur. Adoptive parents, like all other parents, can have no prior assurances

as to how a child will develop. On the other hand, they cannot say, as natural parents can, "He takes after his dad," without arousing in themselves considerable anxious speculation about the child's biological parents. Frequently their fantasies about their child's origin tend to obfuscate their perception of the child's development and to color their expectations of him.[1]

Another subject which provoked considerable discussion was the physical separation of parent and child when the latter enters nursery school or school. Here the concern focused on the teacher-child relationship. "Will the child be 'liked' by the teacher? which seemed to mean: 'Will the teacher approve of what I've been able to do with the child?'" "Will the teacher understand the 'special nature of this child's life experiences, or will she inadvertently disrupt the effort I have made to help him grow up?'" Such questions carried an apprehensive quality related to the fact that in going to school the child is taking on a relationship with a parent surrogate. Perhaps this apprehension grows out of the ultimate fear, expressed openly by some of the adoptive parents, that they will lose the child at maturity to his natural parents.

Problems about the natural parents became the center of the group's most lively discussion. Most of the participants themselves knew, or were aware that someone knew, the identity of the natural parents. Those who had adopted their children through a social agency could fall back on the professional resources of the agency for help with this problem. Those who had adopted privately showed considerable disturbance over the question of what to say to the child when he asks, "Who are my *real* parents?" They seemed to have little conviction that *they* were the child's real parents; that parenthood was something more than a *physical* relationship. Guilt about having adopted, and anxiety over the possibility of losing the child to the "own" parents may have been obstructing such a conviction. Interestingly, this was the only part of the discussion in which hostility to the group leader was expressed. One couple suggested that perhaps the group could have the opinion of "an expert," someone who had had experience with "hundreds of children who were adopted."

Problems About Sex

The second major emphasis was on the problem of sex, in relation to sexual development and the giving of sex information. It should be noted again at this point that the children under discussion fell into two main age groups, between 4 5 and 8 11 years, and that the largest number fell into the top of each group. Thus, most of the children were experiencing intense feelings associated with their particular stage of psychosexual development; the younger children with conflicts associated with the Oedipal phase, and the older ones with the pressures of pubescence and approaching adolescence.

Out of the welter of questions raised about sex, the leader noted two chief concerns: (1) how to explain to the young child "where babies come from"; (2) apprehension over the older child's behavior toward his peers of the opposite sex.

All parents have to deal with the question of when and how to tell children where babies come from. These parents, however, had elaborations of the question, summed up by one parent as: "How can I explain to my 4-year-old where babies come from when I can't tell him that he came out of my tummy." Thus to the adoptive mother, this routine question became emotionally laden as she struggled with her own feelings of incompleteness and inadequacy.

Adolescent Behavior

The concerns over the heterosexual relationships of the older preadolescent child were expressed obliquely, but with considerable evidence of intense feeling. Predominating in the discussion were comments on the observable shifts in the mores of contemporary "youth culture" from those which prevailed "when we were kids." Apprehension over early dating and "going steady," use of makeup, informal "gang" associations, and aggressive behavior permeated this phase of the discussion. It was accompanied by reactions of indignation over the defiant quality of the adolescent protest against parental control and to parents yielding to this kind of behavior.

It is perhaps unjustifiable, on the basis of such a limited experience, to deduce anything special about adoptive parents from the foregoing. After all, society at large has exhibited a considerable amount of concern over precisely these same manifestations of defiance on the part of young people. Nevertheless questions inevitably come to mind when one confronts a group of adoptive parents who are strongly expressing this concern in relation to their adopted children. Does the intensity of the parent's feeling stem from an unconscious apprehension that his child will be unable to deal with the upsurge of sexual feelings which are characteristic of his stage of

psychosexual development? Will he be impelled to "act out" in a deviant way? Since most children who are placed for adoption are the byproducts of uncontrolled sexual behavior, is there perhaps a predisposition on the part of the adoptive parent to project onto the child attributes which were characteristic of the child's natural parents?

Conclusions

While the material in this paper leans heavily toward the problems which emerged in these sessions for adoptive parents, the impulse which brought these people together for a group discussion was obviously a positive one, reflecting real concern with and devotion to their children. Along with their apprehension these parents revealed a real sense of gratification and self-realization gained through the experience of adoption.

On the basis of even this brief appraisal of the way in which unselected adoptive parents openly discussed in a group meeting their concerns about the development of their children, at least one suggestion can be made in relation to the service of adoption agencies. Adoption, while admittedly the most useful social technique available for insuring the normal growth and development of children who have no family of their own, presents to the adopting couple certain psychological problems, which, if unresolved, can rise to trouble the relationship between parent and child. The discussions showed that even where professional help has been available early in the course of the adoptive process, residual feelings can become aroused during the evolution of the parent-child relationship which may disrupt the maturational process. This would seem to suggest that some organized effort might be made to study the implications of this fact in terms of agency services.

Perhaps agencies could offer help to adoptive parents at points which are known to be "critical" in the developmental process of all children, some of which are mentioned in the foregoing material. Such service might properly be offered by agencies whose primary purpose is something other than adoption. This would seem important in order to avoid the anxiety on the part of some parents that the agency which has the power to give can also have the power to take away babies.

One can only echo an "amen" to the suggestion of Viola Bernard: "In my opinion, the mental-health potentialities of this aspect [postadoption service to parents] of adoptive casework have not been sufficiently explored or developed . . . a promising innovation to be considered is to offer parental guidance, individually or in groups to adoptive couples at some period after they have legally adopted."[5]

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[2] Benedek, T.: Infertility as a psychosomatic defense. Fertility and Sterility, November-December 1952.

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II. A COMMUNITY WORKSHOP

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ONE DAY about a year ago, adoptive parents in Dallas, Tex., and the surrounding area held an all-day workshop centered on the uniqueness of being adoptive parents. From its inception the institute was requested, planned, and successfully carried out largely by the adoptive parents themselves.

The plan was originated by the Edna Gladney Auxiliary of Dallas, an organization of adoptive parents whose children had been placed by a large statewide adoption service located in Fort Worth. The auxiliary began by sending a questionnaire to adoptive parents whose names were obtained from several other adoption agencies. The response was encour-

aging, and as the plan developed excellent newspaper publicity in several cities in the area helped to attract adoptive parents whose children had not been placed through agencies.

At the auxiliary's request, a number of social agencies concerned with children joined in sponsoring and planning the workshop. They included the State department of public welfare, the Dallas Council of Social Agencies, the Child Guidance Clinic, the Juvenile Court, the Mental Health Society, the Jewish Family Service, and the Presbyterian Children's Home and Service Agency. A small group of professional people, appointed as a program committee, selected the main speakers and institute leaders.

The Plan

Over two hundred participants registered for all or part of the day, and the registration fees, to the great relief of the planners, who had proceeded mainly on faith, covered honoraria and other expenses. The use of facilities at Southern Methodist University contributed to the smoothness of the day's work.

The plan of the day was for:

1. General session all morning, consisting of: A two-way discussion, first on being a parent and then on the adjustment problems of the adopted child, by a New Orleans psychoanalyst who is consultant for several children's agencies, Dr. Carl Adatto, and the supervisor of the New Orleans Children's Bureau, Rebecca Smith; and a brief question-and-answer period.
2. Workshops limited to 15 persons occupied the early part of the afternoon. Each workshop was led by an experienced group leader—a social worker, psychiatrist, psychologist, minister, teacher, or lawyer. Classifications of workshops were: "The Preschool Child," "The Elementary School Child," "The Adolescent," "The Child Adopted After Infancy," and "Legal Aspects of Adoption."
3. A closing general session, consisting of the leaders' summaries of each workshop and brief summarizing statements by Dr. Adatto and Miss Smith.

Most of the conferees were adoptive parents, with about an equal number of mothers and fathers. A good many social workers also attended, primarily to learn from the parents how adoption looked a few years later.

The adoptive parents were eager, interested, and vocal. Their degree of involvement was so high that the group response to even the large general sessions was readily apparent.

Content and Reactions

Miss Smith began the opening session by speaking generally on being a parent, not specifically an adoptive parent. She spoke of the child's dependence, his need for love and protection, his hostility toward restrictions and his need for them, his great resilience, and his need to use that resilience. Dr. Adatto continued this generalized discussion by speaking of the child's need to know what the world is like, and of the frequent parental fear which seeks to protect the child from cruel facts of life; of the child's need to be told the truth and to become independent.

The restlessness of the audience was physically apparent through this session. The speakers had deliberately chosen to begin by stressing the similarities between adoptive parents and natural parents, but the group would have little of this. From their questions they indicated that they had all received general help on being parents from various parent-education groups in which they participated. What they wanted from this meeting was open and frank airing of the difficulties and differences of adoptive parenthood.

As the discussants moved into the adoption area, they suggested the possibility that adoptive parents try too hard, and asked those assembled whether they were as lenient in looking at themselves and their mistakes as natural parents would be. The discussants then went on to identify one social fact of adoption, from the child's viewpoint, as his feeling of difference, and another as his feeling of having been rejected by his natural parents. They pointed out that while adults can be very tolerant of people who have to give up their children, the child is apt to feel that his mother did not love him enough to keep him, and that this presents a difficult course for adoptive parents to steer: understanding the child's position, while clearly disagreeing with it; and never being critical of the biological parents, because to the child this means being critical of him. They advised that the best way to disagree with the child on this question is to confront him constantly with positive proof of their love, evidence that he is wanted, respected, and worthy of love. The issue of the original rejection must be faced honestly,

they said, and the child's feelings not denied or repressed.

At one point one of the speakers, commenting on the relationship between adoptive parent and child, said that the child may be tangible evidence of the adoptive parent's sterility, a reminder to parents that they could not bear a child of their own. This provoked a markedly negative reaction from the group, one of obviously hostile denial of any such possibility.

Concerns and Attitudes

The 14 workshops differed from each other according to leadership and composition. Some, particularly those concerned with preschool children, discussed the normal development of all children. Parents of older children showed more concern about the differences facing adoptive parents: how to tell the child he is adopted; how far to go in "revealing the facts of background," which usually meant whether or not to tell the child he was born out of wedlock; how to protect the child from the cruelty of questions and taunts of other children and adults; how to handle television programs dealing with adoption in an unfortunate manner.

Two major aspects of parental attitudes were revealed. One, a part of the conscientiousness and eagerness of the adoptive parent, was his desire to protect his child from hurt, either very real or exaggerated by the parent. The other was his own anxiety about his child's origin, in regard both to the child's having been given away by his natural parents and in regard to the illegitimacy.

Some of the parents had adopted their children from agencies which did not have professionally qualified staff at the time. Others had adopted their children without help from any social agency. It seemed to observers that many parents, whether their adopted child had come by way of an agency or another source, had had little help in facing and becoming more comfortable with their own feelings in these areas.

Social workers who attended the meeting, listening more than they participated, almost unanimously expressed guilt about their poor use of the "supervisory" period following agency placement, almost always referred to by adoptive parents as "the probation period." They were genuinely surprised at the degree of anxiety that the adoptive parents reported as having experienced in the 6 months or year during which they felt the eagle eye of the agency always upon them. There was little evidence that the adoptive parents considered this as a helping period, or that the agencies had so used it. There was little evidence that the adoptive parents had felt free to express their negative feelings, their doubts, and their anxieties, either during the study period or during the supervisory period. There was little evidence that the adoptive parents thought of the adoption agency as a resource for help with adoption problems or other parental problems in the years following adoption.

Some of the adoptive parents seemed to feel that the day had reassured them greatly and had given them an opportunity to air feelings never expressed openly before. One father said fervently, "This is the best day I have ever spent." Other parents seemed to feel that they had no problems anyway, and therefore needed and received little help from the meeting. Still others seemed disappointed because no pat answers were given to such questions as exactly how, when, and what to tell a child about his adoption.

In her summarizing remarks, Miss Smith spoke of the new insights into the desires and feelings of adoptive parents gained by the social workers who had participated in the workshop.

Those participants who were not themselves adoptive parents felt a great respect by the end of the day for those who were. The parents' understanding and helpfulness to each other in the small groups were marked. Their humility and self-examination, the intensity of their desire to be good parents, and the obviously high degree of their success were equally noticeable. They needed to hear, as they did from Dr. Adatto, that –

> Adoption is not just our problem; it is also our child's. Being adopted is just as much his problem as it is yours, and you have to let him sweat it out for himself. You can't handle both sides. The child has to work it out his own way, and that is his responsibility. You can help him with it, and guide him, and try to find the easiest way, but you must nevertheless respect his individuality by admitting that it is his problem and he has a right to work it out.

Perhaps they received some encouragement from his closing remarks:

> I've picked up from you that you handle your problems in your own way, sliding into them without trying to push anything and I think that is a sensible approach. But it all adds up to a real awareness, and it is inconceivable to me that your children will not know what went on here today, even if you don't say a word about it. There are a lot of unanswered questions, but the important fact is that the questions were asked in the first place.

A PROCESS FOR IDENTIFYING DISTURBED CHILDREN

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IN A WORLD where the flick of a switch can turn darkness into light, where a spin of a dial can transport a person from the South Pole to an Iowa football field, where one can drive about in a pushbutton car with the assurance that the stove at home will turn the oven off when the meat is done—in such a world it would not be surprising for a kind of faith in magic to be prevalent. Attitudes which result from technology's amazing simplification of everyday time-space problems through easily operated gadgets may be displaced onto problems in the social-personal areas of living. This search for the magical solution is perhaps most evident in the approach to complex problems about which little scientific knowledge is available and which directly involve the human personality. It is especially so in regard to the problem of mental illness.

The search for a kind of psychological penicillin by which mental illness and its associated disabilities could be prevented has been particularly intriguing. Such a search often leads to the discovery or rediscovery that the public school is an institution whose services are available to all the children in the community, which employs professional personnel trained in the understanding of personality development in children, and which can and often does establish ancillary services to help teachers and parents. It is not surprising, then, for agencies dealing with problems created by poor mental health to look to the school as an avenue for reducing the rate of psychological morbidity in our population.

Often the specific request made of the school is: "Identify and help emotionally disturbed children early." The possible effectiveness of early identification in preventing unwholesome personality development rests on at least two assumptions which need scientific clarification. The first is that emotional disturbance is the result of a progressively developing condition visible and susceptible to evaluation early in a person's life. Its corollary is that the school, as now constituted, can recognize this condition economically and within the present framework of daily activities.

The second assumption is that the child who is identified early in life as emotionally disturbed can be helped with less trouble to himself and the community than would be the case at a later period in his life. Although the assumption that the earlier the identification the easier the cure seems both logically and psychologically sound, it is still a proposition based on faith and conviction.

The Study Design

Acknowledging these gaps in knowledge, and in spite of them, the California State Department of Education initiated in September 1955 a study concerned with early identification of emotionally disturbed children. Specifically, the study was aimed at discovering to what extent a teacher-centered procedure might be employed for identifying disturbed children in a class and to what extent information ordinarily obtained by the classroom teacher about children might be used for this purpose. "Identification" was conceived of as a process rather than an act—a process which might favorably affect the teacher's perception of behavior and help point the way to remedial measures. The study plan was based on the assumption that to be effective this process had to be carried out by the teacher as the person in the school most closely involved with the children, the one who had more day-to-day con-

tacts with each child than anyone else on the school staff, and the one who was in the most advantageous position to observe the children's relationships and behavioral patterns.

Before involving the teacher in the study, the study staff asked the psychiatrist, psychologist, or counselor in each participating school to identify some children who were being seen or who had been seen by the clinical staff and who in their opinion were "emotionally disturbed." Classes in which one or more of these children were enrolled were then selected for participation in the study without revealing to the teacher the criterion for selection.

The purpose of the study, as explained to the teachers, was to study all the children in the class. Some of the teachers knew that some of the children in their classes had been seen by the school psychologist or clinic; others did not. In any case, the only knowledge the study staff wished to keep from the teacher was the reason for the selection of her class. This, the staff felt, would be necessary to prevent the research itself from biasing the teacher's perception of her children.

Several conditions were agreed upon by the study staff and the schools in regard to the information the teachers would be asked to collect. These were:

1. It could be obtained by teachers in their everyday, routine interaction with the class.

2. Gathering and recording it would not involve a disproportionate amount of teacher time.

3. The type of data expected could be so defined as to have the same operational meaning to each teacher.

4. It would tap as many sources as economically possible for indication of the child's behavior.

5. The information-gathering procedure would allow the part of "suspectician" to fit harmoniously and acceptably into the teacher's perception of her role and responsibilities.

The categories of information finally selected for the teachers to collect about each child were:

1. Individual scores from group intelligence test.

2. Individual scores from group achievement test in arithmetic and reading.

3. Individual responses to a group administered personality inventory, "Thinking About Yourself."[1]

4. Results of a sociogram, "The Class Play."[2]

5. Age-grade relationship.

6. Rate of absence.

7. Rating of socioeconomic index based on father's occupation.

8. Teacher's rating of the child's physical status.

9. Teacher's rating of the child's emotional status.

Table I.—TEACHER RATING OF EACH CHILD IN RESPONSE TO: HOW WOULD YOU RATE THIS CHILD'S ADJUSTMENT WITH RESPECT TO HIS PRESENT GROUP?

Rating	Males		Females		Total	
	Number	Percent	Number	Percent	Number	Percent
TOTAL GROUP						
Among the best	673	23.0	893	33.5	1,566	28.0
Among the average	1,368	46.9	1,314	49.3	2,682	48.0
Among the poorest	879	30.1	460	17.2	1,339	24.0
Total	2,920	52.3	2,667	47.7	5,587	100.0
EMOTIONALLY DISTURBED GROUP						
Among the best	3	1.9	2	4.5	5	2.4
Among the average	17	10.4	5	11.4	22	10.7
Among the poorest	142	87.7	37	84.1	179	86.9
Total	162	78.6	44	21.4	206	100.0

Information in all these categories was collected on approximately 4,400 children by approximately 200 teachers of fourth, fifth, and sixth grades in about 75 school districts. Among the children were 207 clinically designated emotionally disturbed children—162 boys, 45 girls.

In the instructions to the clinicians no sex ratio for selection was indicated. It is interesting to note that the resultant random selection resulted in a ratio of emotionally disturbed boys and girls very close to the ratio of referrals.

The information was collected by each teacher for all the children in her class on a special form devised by the State department of education and returned to the department for processing.

The first analysis of the data was to determine to what extent, if any, this information could help a teacher to differentiate the emotionally disturbed child from the rest of the children in the class, how many emotionally disturbed children there were in the school population, how they were perceived by other children, and how they perceived themselves. It was proposed that as part of this study the data which significantly differentiated the emotionally disturbed child from the others be analyzed to discover the degree of differentiation. Then each item

Table II.—TEACHER RATING OF EACH CHILD IN RESPONSE TO: IS THIS CHILD OVERLY AGGRESSIVE OR DEFIANT?

Rating	Males		Females		Total	
	Number	Percent	Number	Percent	Number	Percent
TOTAL GROUP						
Seldom or never	1,579	54.0	1,945	73.0	3,521	63.0
Not very often	709	24.2	401	15.1	1,113	19.9
Quite often	469	16.0	239	9.0	708	12.7
Most of the time	169	5.8	78	2.9	247	4.4
Total	2,926	52.3	2,666	47.7	5,592	100.0
EMOTIONALLY DISTURBED GROUP						
Seldom or never	31	19.1	17	37.8	48	23.2
Not very often	27	16.7	6	13.3	33	15.9
Quite often	57	35.2	15	33.3	72	34.8
Most of the time	47	29.0	7	15.6	54	26.1
Total	162	78.2	45	21.8	207	100.0

Table III.—TEACHER RATING OF EACH CHILD IN RESPONSE TO: IS THIS CHILD OVERLY WITHDRAWN OR TIMID?

Rating	Males		Females		Total	
	Number	Percent	Number	Percent	Number	Percent
TOTAL GROUP						
Seldom or never	1,700	58.1	1,367	51.2	3,067	54.8
Not very often	732	25.0	699	26.2	1,431	25.6
Quite often	351	12.0	406	15.2	757	13.5
Most of the time	144	4.9	197	7.4	341	6.1
Total	2,927	52.3	2,669	47.7	5,596	100.0
EMOTIONALLY DISTURBED GROUP						
Seldom or never	87	53.7	15	33.3	102	49.3
Not very often	40	24.7	14	31.1	54	26.1
Quite often	20	12.3	9	20.0	29	14.0
Most of the time	15	9.3	7	15.6	22	10.6
Total	162	78.3	45	21.7	207	100.0

of the differentiating data would be weighted in proportion to the size of its ability to differentiate. For example, if *The Class Play* technique and group I. Q. scores both turned out to be significant but one turned out to be twice as discriminating as the other, they would be weighted accordingly. After the weights were assigned, the data and the weights would be tried out by a variety of teachers and classes to learn what corrections, additions, or subtractions needed to be made in the process.

The Findings

A detailed report of the results of this study will soon be published by the California State Department of Education. Following is a brief summary of the aspects of the information collected by each teacher which differentiate the emotionally disturbed children (those selected by the clinicians) from others of their classroom. (In all these statements the word "significantly" refers to the 0.01 level of confidence, meaning that there would be one chance in a hundred that a difference as large as the obtained difference would occur by chance. "They" refers to the selected emotionally disturbed group.)

1. The emotionally disturbed children scored significantly lower on group I. Q. tests. On psychological tests given individually, they approached the mean of the group.

2. They scored significantly lower on reading and arithmetic achievement tests. The differences were greater and more significant on arithmetic achievement. The higher the school grade, the greater the differences between the emotionally disturbed child and the rest of the class.

3. They differed significantly from the other children in the class in their self-perception as revealed in some of the items in the Personality Inventory. Emotionally disturbed boys exhibited greater dissatisfaction with self and their school behavior than the other boys. Emotionally disturbed girls showed less dissatisfaction with self than the rest of the girls in the class.

4. On the sociogram, "The Class Play," the other children in the class tended to select emotionally disturbed children for hostile, inadequate, or negative roles and failed to select them for the positive, good roles. Hostile children particularly were selected for roles consistent with their behavior.

5. The emotionally disturbed children came from homes which were not significantly different in socioeconomic level from those of other children generally. (This fact was revealed by a chi-square test comparing the distribution of the occupations of the fathers of the emotionally disturbed children and the occupations of the fathers of the rest of the children in the class.)

6. Altogether 87 percent of the clinically known emotionally disturbed children were rated by their classroom teachers as among the most poorly adjusted children in the class. (Table I.) Nearly 61 percent of these were described by the teachers

as being overly aggressive or defiant often or most of the time (Table II), while 25 percent were designated as being overly withdrawn or timid quite often or most of the time (Table III). As perceived by teachers, 4.4 percent of all the children in the class were overly aggressive or defiant most of the time (Table II), while 6.1 percent were overly withdrawn or timid most of the time (Table III).

Some of the implications of the study might have been expected. Others may be more surprising. Here are a few:

1. Children's judgments of other children's personality are surprisingly accurate and predictive.

2. Teachers' judgments of emotional disturbance are very much like the judgment of clinicians.

3. Teachers in this study selected a greater number of children as being overly withdrawn or timid most of the time than as overly aggressive or defiant most of the time.

4. At least three children in each average classroom can be regarded as having emotional problems of sufficient strength to warrant the appellation "emotionally disturbed child."

5. The differences between emotionally disturbed children and the others seem to increase with each grade level. In essence, the rich get richer while the poor get poorer.

A Psychological Thermometer

It should be reemphasized that this study was aimed at securing a "psychological thermometer" about schoolchildren for persons in a favorable position to use such a device, and at nothing more. Like the medicine-chest thermometer which may add little information to the obvious fact that a person has a high temperature, such a psychological thermometer may confirm a suspicion, reject a suspicion, or raise a suspicion. It may provide teachers with a more accurate base than personal supposition for communicating with specialists, as well as a possible gage from which individual change can be assessed. It may provide the teacher with a method for evaluating her own processes. It may also raise pertinent questions in a teacher's mind, particularly when it does not confirm her judgment about a specific child or when it indicates that a formerly unnoticed child might be having difficulties.

For example, a teacher reported that the sociogram, "The Class Play" (a device in which children select roles for themselves and other members of the class for a hypothetical play), did not seem to be a very reliable method for learning about the children since some of the results in her class did not coincide with her observations. She noted that a child whom she saw as a leader of the class was not chosen as such by the other children. When asked whether both perceptions might not be correct, she answered: "Well, he always seems to be a leader when I'm around." But a few weeks later she reported that the other children did feel differently about the child than she had supposed.

"You know," this teacher observed, "it's interesting really to find out that your idea about a child isn't the only one. I think I see him a little differently now because I am also able to accept how others see him."

One part of "The Class Play" provides for a comparison of the role each child selected for himself and the roles selected for him by his classmates. Thus it serves as a device for studying the reality-testing aspects of a child's personality and for making some inferences about how a child sees himself and how others see him.

A highly intelligent fifth-grade girl who was chosen for many negative and hostile roles by her classmates chose negative roles for herself when asked which parts she thought her classmates would choose her to play and which parts her teacher would ask her to play. But in answer to the question, "Which part would you like to play?" she chose the heroine role. Later this girl told her teacher that she realized how her classmates felt about her but that she felt she was gaining greater understanding of herself, "that she knew what she was up against and was working on it."

A boy received 8 positive and 8 negative choices by the class. His teacher found that his nickname among the children, "Little Nuisance," was an honest reflection of the mixture of affection and irritation his classmates felt in regard to him. The boy saw himself as the class did, choosing himself for an equal number of appropriate positive and negative roles, and accepted the appellation with good grace. Other parts of the data gathered on this child by the teacher led her to a more meaningful understanding of how this child perceived himself and how other children reacted to him.

Possibilities of Process

This process for helping the teacher identify the emotionally disturbed children in her class might be regarded as a kind of action research with two major purposes: (1) to help the teacher understand the relativity of her perception of the children; (2) to provide teachers with a systematic, meaningful procedure for using available information about children in verifying or rejecting hypotheses about their adjustment status.

As Coladarci[7] points out, "the teacher must be an active, continuous inquirer into the validity of his

own procedures." This process may very well help the teacher become a more effective inquirer.

It is also possible that this process might be helpful to the teacher-clinical staff relationships.

An emotionally disturbed child whose behavior is erratic or disrupting can and often does induce anxiety and despair in a teacher: Often the relationship of the class and teacher to the emotionally disturbed child is such that no solution but separation of the child from the group is acceptable. When this point is reached, the teacher often seeks the help of the clinician as a "waver of the magic wand" – that is, as a person who can solve the problem quickly either by changing the child's personality or by changing his room. It is sometimes difficult for the teacher to accept the fact that her expectations cannot be met and that she must participate in the slow process of "understanding" the child.

Intellectually the teacher may recognize the limitations of the clinical service; emotionally, however, she may be disappointed that nothing happens and that she is still plagued with the problem. In time, therefore, she may come to feel that the clinical service offers little to help her. The psychologist or guidance worker on the other hand may be so overwhelmed by the numbers and seriousness of problems brought to them that he becomes immersed solely in the clinical nature of his task. As Krugman points out, "Because there is almost never sufficient staff in a school-guidance program to do what needs to be done, the tendency is usually to focus on emergencies or immediately annoying problems . . . . We still have too great a tendency to throw our full armamentarium of personality appraisal methods into efforts to salvage the problem child." [4]

The anxiety induced in a teacher by one or more emotionally disturbed children is often visited upon all the children in the class. As a result those children with situational or incipient problems who can be helped by the teacher may be overlooked or overevaluated. However, a teacher who "knows" the children and the class may be more comfortable about seeking help and more aware of her own personal anxieties and biases in appraising children. It may be necessary at times for a teacher to accept the fact that some children are seriously disturbed and need psychiatric treatment. The number and urgency of serious problems may be greatly reduced, however, if the teacher-clinical team can be helped to make the most of the school's potential for preventing personality distortions in children.

This preliminary investigation has approached the problem of identification by backing into it – ascertaining certain relationships between the emotionally disturbed child and his school environment. In order to test the on-the job validity of the process of identifying such children by comparing the factors in these relationships, the teachers in a number of schools of various types will be given the opportunity to use it. The focus of research may then be shifted to seek answers to such questions as:

1. What, if anything, happens to the teacher as she uses this procedure?

2. What happens to her relationships to the children and to the clinician?

3. What kinds of children are referred or discussed?

4. Are there changes in the quality and levels of relationships?

5. Which children, who should have been identified, were not?

For the most part we have been attempting to promote mental health in our society by trying to deal with the consequences of mental illness and its allied manifestations. This is about as effective as trying to turn back the Mississippi at New Orleans. Not that we don't need dikes and erosion prevention up and down the line. But, as Daniel Blain has asked, "Is it not possible to build dams higher up the stream and to plant more trees on the slopes and hold the water in?" [5]

Certainly there are at present no magic buttons which we can push to insure increased amounts of emotional maturity for our future citizens. It would seem most profitable, however, to attack the problem of enhancing personality growth at definite points with specific programs of action and evaluation. For if there is a potential for magic, it lies in the resiliency of the child. Perhaps through this and similar projects it will be possible to learn more of the exact nature of this resiliency and how we can make the most of it in promoting mental health.

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[1] California State Department of Education: Thinking about yourself. Sacramento, 1957.

[2] California State Department of Education: The class play. Sacramento, 1957.

[3] Coladarci, Arthur: The relevancy of educational psychology. Educational Leadership, May 1956 (p. 490).

[4] Krugman, M.: Appraisal and treatment of personality problems in a guidance program. *In* Education in a free world. Washington, American Council on Education, 1954 (p. 114-124).

[5] Blain, Daniel: In a speech at the Western Interstate Commission on Mental Health, Salt Lake City, June 2, 1956.

A COMMUNITY-CENTERED SCHOOL IN MANILA

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DEMOCRATIC EDUCATION requires that all children be given equal opportunity to develop the best that is within them for competent participation in a wholesome and satisfying life. Because individual children develop and grow in different ways from one another, have varying abilities and rates of learning, and respond differently to social situations, the achievement of this goal confronts the public schools with personal and social problems. In the Philippines such problems are aggravated in many areas by widespread insecurity and want.

After the war, the high cost of living made it impossible for many families to maintain their previous standard of living. Today only the rich can afford the things most Americans take for granted. Though middle-income families live comfortably they have to go without many of the things Americans consider necessities. For low-income families who have to scrimp for a bare livelihood many essentials for healthy living are completely out of reach.

About 7 years ago, the Philippine Bureau of Public Schools launched its community-centered schools as one way of meeting the challenge of these problems. Already, evidences of their effectiveness in improving community living are appearing. Their organization, activities, and techniques have gone beyond the pioneering stage. They are now going concerns throughout the Islands. Although differences exist among the various community-centered schools of the Philippines, some elements are common to them all, especially those relating to concept and underlying principles.

The community-centered school functions on the idea that the school should not only teach its pupils the accumulated knowledge of the past and help them acquire learning skills, but that it should also help to make the community a better place to live in for everyone. It is based on the following principles:

1. The school should operate as a center for children and adults.

2. It should call on community resources to invigorate efforts toward community improvement.

3. It should actively participate in community activities.

4. It should center its curriculum on a study of the community social structure, processes, and problems.

5. It should lead in coordinating the educative and social-welfare efforts of the community.

6. Children and adults should be enlisted in cooperative group projects of common interest and mutual concern.

The idea of the community-centered school is not new. It has been advocated and practiced in some other parts of the world. However, it is a fresh educational and social approach for the Philippines. Until it was adopted the schools had traditionally emphasized learning skill and the acquisition of knowledge ever since the establishment of the public-school system in 1901. As a consequence, education had not been able to make profound changes in the community and the life of the people as a whole, particularly rural areas.

The old schoolhouse was like a castle surrounded by moat and walls. The children, once inside, were under the authority of the teachers who knew, or

at least thought they knew, what was good for them. There were prescribed facts that were to be taught and learned regardless of whether the children were interested in them or had use for them in their lives. Parents were called to school only when their children misbehaved. Their main responsibility in regard to the school was to see that the children did what the teacher demanded and to send the children to school on time.

The failure of education to improve community life has long bothered some Filipino educators and social workers. After World War II, the number of concerned people increased to such an extent that the public schools came to accept the concept of the community-centered school which serves not only the children of the community but also the adults and out-of-school youth.

Community Participation

One of the first schools reorganized along these lines was the Padre Gomez Elementary School in the heart of the city of Manila. About two-thirds of the people of the area from which this school draws its pupils are families of middle income; about one-third are low-income slum dwellers.

In the Padre Gomez School officials are attempting to meet their responsibility to children by providing auxiliary personnel qualified by professional training and understanding of children and their problems and helping them to make satisfying use of the opportunities the school has to offer. Supervisors, doctors, nurses, remedial-reading teachers, speech teachers, psychologists, and counseling and guidance teachers, these staff members work both through the classroom teachers and directly with the child. But most important is the participation of parents not only in school activities and school planning but in cooperative self-help programs to enrich their own and their neighbors' lives.

Today all public schools in the Philippines are community centered, though to varying degrees. Their services vary, depending on the conditions obtaining in the particular community in which a public school is located, but the movement has flourished in both urban and rural communities.

In all these communities parents frequently visit the classrooms not only to exchange views with the teacher on their own child's progress or problems but to participate in community surveys and help plan school and community programs. In rural areas especially the school serves the whole community and helps the inhabitants to improve their mode of living. With the emphasis on doing rather than teaching, homes have been renovated by school stimulated cooperative projects in which neighbors help each other install screens and privies, repair thatched roofs, clear fields, plant vegetable and flower gardens and otherwise make their homes more livable.

In the urban areas the school curriculum has been vitalized by cooking classes in which parents and children take part, literacy classes for parents and grandparents, field trips for the children to factories and historical sites. School-sponsored neighborhood cleanup campaigns give the children a chance to participate in community improvement and to help educate their parents. Adult discussion groups of national and community affairs spur the development of a healthy public opinion.

Center of all this activity is the purok, or neighborhood association of 25 to 50 families, each with its elected leaders. Today there are some 65,000 puroks throughout the country with more than 4,000,000 members.

The purok begins with a teacher-layman meeting at which officers are elected and committees created for studying community conditions and resources. The data gathered by the committees become the subject of class discussions, purok meetings, and community conferences and eventually result in co-

A school social worker interviews a bright boy who has been irregular in school attendance. This aspect of the Manila schools' service owes much to the author's observation of school social work as practiced in the United States.

operative projects for social as well as economic reconstruction. The projects are developed and carried out by the people themselves for which the school has become the catalyzer for action.

School Services

In thus becoming a center of community life the school has also become a logical center for recreational activities and provision or coordination of health and social services. What it does in regard to these last depends largely on what is available in the community. For instance, since the Padre Gomez School is located in a large urban area in which both public and private health and welfare services are available to some degree, a large part of the school's service job is to refer children and their parents to the appropriate services. Some services, however, are given directly, because of the need for them. Since the local public-health clinic could not possibly meet all the health needs of the 4,000 families in the neighborhood, the school provides a clinic which gives the school children dental services, and medical services for those with minor ailments, referring more serious cases to the local clinic or private physicians. Preschool children are served by the local clinic.

The main emphasis of the school's health services is on health education. While the school nurse in the course of home visits acquaints families with ways of maintaining health, all the members of the school personnel disseminate health information as they carry out their other tasks.

Parents are encouraged to use the school library, which carries magazines, papers, and books containing materials on the growth and development of children, written in simple language.

The school's counseling teacher provides personal guidance to parents, teachers, and children, thus uniting the efforts of the home, the school and the community in the prevention as well as in the solution of problems which interfere with children's successful participation in school experience. In her work she especially reflects the school's concern about the child who has not enrolled in school, the habitually absent child, the aggressive and belligerent child, the shy and withdrawn child, and the child suffering from a physical or mental condition affecting his participation in school life.

Trained to interpret child behavior, the counseling teacher studies the social conditions which affect the child. Besides working with the principal, the classroom teacher, the supervisor, the parent, and the child himself, she uses the services offered through other community agencies.

In instances of serious social problems or personal maladjustment the counseling teacher refers the child to the local office of the Philippine Social Welfare Administration, to a mental-hygiene clinic or to an individual psychiatrist or psychologist, supplying the agency or practitioner with appropriate information, and keeping in close touch with them afterwards. In most rural communities, however, such facilities are not available, nor are there, as yet, any special counseling teachers. Until these can be provided—and the hope is that there will be some such service in the future—the burden of helping the child and his parents with his problems must fall on the classroom teachers.

The counseling teacher's major tasks are: (1) interpretation of her findings to parents and teachers; (2) coordination of school and community services; (3) keeping confidential records on children with problems; (4) provision of individual counseling to parents or children seeking help with problems; (5) cooperative planning with the school supervisory staff.

The school's place in the community also makes it the logical place for old and young to seek recreational opportunities. Consequently the Gomez school facilities, such as playgrounds and social hall, are kept open after school hours and throughout the year. Under the aegis of the school community council, composed of purok leaders, the social hall is used for educational movies, dramatics, folk dancing, folk singing, social dancing and concerts in addition to community conferences.

The community school's interest in parent and community has resulted in a deep interest in the school on the part of the community, especially parents, in the school's total program. At Gomez parents are welcome in the classrooms at any time for experience has shown that when they thus find out for themselves what the teachers are trying to do they become missionaries for the school, influencing other parents' attitudes toward school attendance on the part of their children and toward their children's other needs.

The parents also help the counseling teacher and the other school personnel plan approaches to children's problems. They work with the counseling teacher, for instance, on ways of dealing with parents who believe it all right for children to miss school time to work in a factory—not an uncommon

attitude in our area. Much of the counseling teacher's work is necessarily involved with community attitudes.

At Gomez, as at all community-centered schools, the curriculum is built around the major processes and problems of human living. It belongs to the community, not primarily to the educators. The community coordinating council, the parents, the social agencies, the health agencies, bring their experience and knowledge to bear in the "thinking through" of school problems with the school administrators.

Initial Problems

Setting up and operating a community-centered school is not without its problems. In Padre Gomez these have been:

1. Shortage of professional personnel, particularly of persons trained in social work and community organization.

2. The conditions under which the staff work. Counseling teachers have caseloads far over the "ideal" average of 30.

3. An early tendency, now overcome, to subordinate the health and social-work aspects of the program.

4. Early difficulties, also now disappearing, in achieving cooperation between other social agencies and the school.

5. Reluctance on the part of some school officials to broaden the school's focus to its present scope.

As a consultant to counseling teachers I have been intimately concerned with efforts to solve these problems and in this work have drawn heavily on knowledge and skills I learned in social-work study in the United States under the United Nations technical-assistance program. Since a community-centered school is not a school pattern commonly found in the United States, if it is there at all, application of this type of training to the Philippines school scene has required some imagination and ingenuity. But it has been a great push to the four basic wheels on which the program proceeds:

1. The counseling process. The counseling teacher relies fundamentally on her ability to conduct an interview, guiding it to constructive ends.

2. Understanding the child. Knowledge of the normal processes of growth and development is, of course, basic to the understanding of the social, health or educational aspects of problems in children.

The school nurse, fifth from right, conducts a mothers' class in how to take care of the sick, while the author, fourth from left, observes. This 6 weeks' course is one of the community services aspects of the Padre Gomez School.

3. Community study. The liabilities and assets of the community as they affect children's growth and health must be kept clearly in mind in dealing with individual children. Community study gives the counseling teacher a broader concept of the wide range of community agencies and services that can help the schoolchildren.

4. The groupwork process. At Gomez we find that our teachers develop understanding and skill in handling children by taking part in cooperative studies of the social and economic problems of the community that affect children's growth and development, as well as participating in workshops and study groups more specifically designed to help adults improve their work with children. The teachers plan out areas of study decided upon by members of the group. Some of the topics that receive considerable emphasis are: principles of child growth and development; techniques of child study; services of agencies working with children; and the teacher's work in the total school program.

In putting such a heavy social and health emphasis in our school program we in the Philippines do not mean to belittle the value of learning as such. Rather we make the emphasis out of the belief that the educational level of the Philippine people will rise only as they achieve a greater measure of health and social well-being.

POINT OF AGREEMENT

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United thoughts and counsels, equal hope
And hazard in the glorious enterprise—*Milton*

EXPRESSION of difference may be the dynamic factor in helping to bring about a progressive approach to the solution of fundamental problems. At some point, however, agreement—rather than expression of differences—is essential if an all-out attack is to take place and ground to be gained. Two recent additions to the literature of child welfare have achieved such agreement, notwithstanding the fact that in certain externals such as size and focus they differ considerably.

One of the publications is *Casework Services for Children: principles and practices*, by Henrietta Gordon.[1] Although Mrs. Gordon is director of information and publications of the Child Welfare League of America, her statement of practices and principles is not presented as the league's official position. Running to nearly 500 pages and containing an excellently selected bibliography and a useful index, the volume discusses in considerable detail the "seven basic casework services for children whose parents need help in providing adequately for their care and guidance." These seven areas—boarding-home care, institutional care, adoption, day care, homemaker service, protective service, and casework in the child's own home—are considered from a technical point of view, so that the book seems to be presented as a "textbook" for child-welfare personnel—agency staff, social-work students, and members of boards and planning councils.

The other work is the Children's Bureau publication, *Child Welfare Services: how they help children and their parents*,[2] prepared by the Bureau staff, with Annie Lee Sandusky as the writer. Pamphlet-like in form and size (94 pages), the Bureau's publication presents a short, succinct, but thoroughly articulated statement of the child-welfare programs which have already been developed, and looks forward to the time when these services will be available to all children who need them for healthy growth.

These publications are not competing works, for each has a separate purpose. What stands out, however, when the two are viewed together, is their complementary relationship and their essential agreement as to basic postulates upon which a sound child-welfare practice might well be formulated.

Areas of Agreement

What then are some of the points of agreement in these two publications that indicate the existence of a secure, united front?

First is *the rediscovery of parents.* To be sure, child-welfare workers throughout the present century have paid increasing attention to both the rights and the needs of the parents of the children whom they served. Certainly in dealing with a child's problem they have long recognized the influences of early parent-child relationship. By and large, they have in the past supported proposals of income security which would help to insure the maintenance of "own" homes. They have also stressed the importance of parent participation in placement planning and care. Yet in spite of all this, and much more, it is only during the last few years—the past decade particularly—that the parent-child relationship has truly become the "guideline" for all operational aspects of child welfare.

This rediscovery of parents means the end of the old dichotomy of family social work versus child welfare. When the essential aim of child welfare is to supply a disadvantaged child with family living in order to assure a wholesome and healthy per-

sonality development, the task reaches into a variety of settings or situations in which the child is or into which he may go. No one part constitutes the whole.

A second point of agreement is on *the need for personnel within the field to have an enlarged concept of "growth and development."* Both works stress a mastery of child-development knowledge as a sine qua non for doing child-welfare work. To a certain extent this emphasis is not new. What is new, however, are two derivative emphases: (1) the need for child welfare workers to be skilled in nonverbal as well as verbal ways of communication in order to be able to relate to children of all ages and phases; (2) the need for child-welfare workers to see the dynamic potentialities in parenthood.

This last means that child-welfare workers must not be willing to settle for parents' achieving just bare normalcy, or conventional respectability. What stands out in both *Casework Services for Children* and *Child Welfare Services* is the authors' faith, reinforced by experience and fortified with new knowledge, in the potentialities of parents to move to a high level of performance if they are provided with services which free them to come to grips with their particular problem.

A Social Service

A third, and perhaps central, proposition to be found in both publications can be put thusly: *The child-welfare worker is the link that runs throughout the helping relationship and binds the efforts of a variety of people together for the benefit of the child.* This proposition subsumes that the child-welfare worker is now freed of the fear of getting out of her bailiwick into "family welfare" work, and is released from an overidentification with the child as the only one who can change and develop. It therefore means that the worker is at liberty, as well as under necessity, to do many things for children within a family setting.

Among other things that child-welfare workers will have to do are: effecting, maintaining, and ending various types of relationships with adults as well as with children; furnishing information; and providing specific services within and outside of the agency. None of these activities add up to child-welfare work per se. They truly become child-welfare work only when the worker views herself as the representative of the community, so designated, and so vocationally equipped, to see that children are provided with the kind of parenting that is conducive to wholesome and healthy personality development. In other words, the role of the child welfare worker is to see that a given child benefits from a given social institution, namely the family. In this sense child welfare work must be seen as a social, rather than a psychological, service.

A fourth proposition—writ large in both publications—is to the effect that *comprehensiveness rather than competitiveness of programs and services must prevail.* No one type of service is sacrosanct within the field of child welfare.

Certainly a corollary of this formulation is that the old traditional rivalry between foster-home care and institutional care must be eliminated. This does not mean there is no place for the traditional type of institution as well as other forms of group care including the now much-in-vogue residential treatment centers. It does mean, however, that the final goal of child welfare is never group care except in instances of marked pathology.

The final goal of child welfare is that children secure the real and genuine parenting they need and are entitled to in a "good society." If at some point some form of group care can be used to facilitate the achievement of this goal, then it should be provided. The same goes for foster-home care, adoption, day care, protective care, or casework service to the child in his own home or to his parents while he remains at home. In essence, the final evaluation of a child-welfare system in any community must be determined by the answers it can give to these two questions: (1) Are all the necessary services available to insure the kind of family life conducive to wholesome and healthy personality development of children? (2) Are these services so structured and so operated that they can be readily, selectively, and flexibly utilized when needed?

Community Organization

A fifth point of agreement is a reaffirmation of the theory that *child welfare by operational necessity involves community organization as well as casework activity.* Both publications stress this point notwithstanding the fact that one of them, Mrs. Gordon's, is directed by title to "the casework" side of child welfare. It is Mrs. Gordon's book that states: "Indeed it is generally recognized that even the most adequate children's casework service cannot alone assure appropriate care for children unless the community also provides a variety of social services which will help adults as well as children in solving their problems."

For child-welfare workers to be indifferent to

the need for community services which strengthen and maintain family life is to be professionally irresponsible. To be sure, what kind of community organization efforts they should undertake is still a question calling for further thought and discussion. Certainly the process of community organization for child welfare has not been thought out with the professional thoroughness that has been achieved in relation to the child-welfare casework process. Still, some of the benchmarks of community organization have been identified: facts must be established and systematically reported to the community; lay leadership must be properly developed; volunteers must be trained to carry out their function responsibly; legislators must be encouraged to revise old laws and enact new ones; and administrative structure must be refined or modified. In nature, such activities may seem to child-welfare workers to be quite different from helping a parent decide when or where to place a child, but actually they are part of the whole job of seeing that children get the family care they need!

Postscript

Of course, a state of intellectual agreement does not necessarily produce widespread change. Old ways of doing things, even though obsolete and contradictory, tend to linger on and make themselves felt operationally in spite of the lip service given to the new. Even when new principles are generally embraced professionally, administrative implementation does not take place immediately—sometimes not at all.

Frequently behind the failure to implement accepted principles administratively is the need for money. At other times, this failure stems not so much from a lack of money as from a lack of proper or qualified personnel who can and are willing to carry out the newly agreed upon.

This lack of properly qualified personnel has for a long time been a limiting factor in child welfare. Certainly, the child-welfare-services funds available for educational purposes since the passage of the Social Security Act have helped; but not enough. The 1956 amendments to the act permitting grants to the States for the development of services for public-assistance clients and for the educational improvement of public-assistance workers should help considerably. The increased interest and financial contributions to all phases of higher education is also an encouraging sign.

Still, there is a long way to go; but the going is not so difficult when there is agreement on principles!

Gordon, Henrietta: Casework services for children: principles and practices. Boston: Houghton Mifflin Co., 1956. 493 pp. $5.50.

Children's Bureau, U. S. Department of Health, Education, and Welfare: Child welfare services: how they help children and their parents. Pub. 359. Washington, D. C.: U. S. Government Printing Office, 1957. 94 pp. 35 cents.

GUIDES AND REPORTS

RESOURCES FOR SPECIAL EDUCATION. Edited by Merle E. Frampton and Elena D. Gall. Porter Sargent, Boston, 1956. 250 pp. $2.20 paper; $3.50 cloth.

Lists official and voluntary groups serving gifted children and persons with various types of handicaps; includes a classified bibliography.

MENTAL HEALTH ASPECTS OF SOCIAL WORK IN PUBLIC HEALTH; based on the proceedings of an institute given by the School of Social Welfare, University of California, Berkeley, June 6-8, 1955. Gerald Caplan. Edited by Ruth Cooper. Preface by Virginia Insley. 1956. 293 pp. A limited number of copies available without charge from the School of Social Welfare.

Sets forth a general body of knowledge that a medical social worker needs for giving consultation to other workers in maternal and child health, and presents techniques in applying that knowledge. Describes consultation given at the Family Health Clinic, conducted by the Harvard University School of Public Health, at which the author is the mental-health consultant.

FEE CHARGING OR PAYMENT PLANS FOR ADOPTION, CHILD PLACEMENT, AND MATERNITY CARE IN NEW YORK CITY; a survey of current policies and practices. Community Council of Greater New York, 44 East 23d Street, New York 10, N. Y. 1957. 50 pp. $1.

Shows that in New York City adoption agencies vary widely in their policies on fee charging; that 92 percent of children in foster care are maintained through public funds; and that a group of agencies with programs for unmarried mothers receive one-sixth of their income from clients, one-fourth from public funds, and the rest from private givers. No woman is refused service by these agencies because she is unable or unwilling to pay, the report says.

BOOK NOTES

SOCIAL WORK YEAR BOOK, 1957: a description of organized activities in social work and in related fields. Thirteenth issue. Edited by Russell H. Kurtz. National Association of Social Workers, New York. 1957. 752 pp. $7.50.

This reference book is divided into three parts. Part 1 includes three articles on the development and present context of social work in the United States; part 2 consists of 68 topical articles on various areas of social-work concern; part 3 is made up of four directories of agencies—international, national governmental, national voluntary, and Canadian. The appendix lists periodicals mentioned in the bibliographies at the end of the articles.

This edition is the first published since 1954 and the first issued under the auspices of the National Association of Social Workers. It adds five subjects not included in the previous issue: "Intergroup Relations," "Mental Retardation," "The Personnel of Social Welfare," "Social Action," and "Supervision in Social Work." The one 1954 subject not in the new edition is "Group Psychotherapy."

PSYCHOPATHY AND DELINQUENCY. William McCord and Joan McCord. Grune & Stratton, New York. 1956. 230 pp. $6.50.

Pointing out that psychopathy is the most expensive and most destructive of all known forms of aberrant behavior, the authors of this book discuss present and past concepts of this disorder; difficulties in diagnosis; treatment; and the relations between the psychopath, the law, and society.

Noting results of various methods of treatment, the authors report them all to be almost completely ineffectual with adults, though perhaps more hopeful for children. Referring to the evidence on the effects of treatment on children as "admittedly inadequate and partly contradictory," they suggest that "milieu therapy" may be the most promising method.

Introduced after World War I in Vienna and used during the past two decades in several schools in the United States, milieu therapy is described in the book as it is carried out in the Wiltwyck School, a voluntary institution for emotionally disturbed boys. The authors report the results of tests which indicate definite improvement in the psychopaths, listing as factors which seem to have played primary roles in the changes: rapport with adults; nonfrustration; group influence; and individual counseling.

THE YOUNG CHILD IN SCHOOL. Clark E. Monstakas and Minnie Perrin Berson. Introduction by Pauline Park Wilson Knapp, director of the Merrill-Palmer School. William Morrow & Co., New York. 1956. 256 pp. $4.

The importance of the nursery teacher's achieving consistency between her theory and her practice is stressed by the authors, both of the staff of the Merrill-Palmer School, reporting on theory and practice in 312 nursery centers.

The authors describe and illustrate the characteristics of four current theories of education—laissez faire, authoritarian, democratic, and child centered—and present figures showing theory and practice in the various types of centers in relation to motor activity, health and safety; emotional climate; social behavior; intellectual and artistic expression; and parent-teacher interaction.

CRESTWOOD HEIGHTS: a study of the culture of suburban life. John R. Seeley, R. Alexander Sim, and Elizabeth W. Loosley. Introduction by David Riesman. Basic Books, New York. 1956. 505 pp. $6.50.

This book presents a report on a 3-year pilot research project in mental health, which was financed by grants to a university by the Canadian Government as part of a larger experiment. It describes the social life of an upper-middle-class suburban community with special reference to the child-rearing process and its implications for mental health.

On the basis of interviews with parents and young people and of experience with special "human-relations" groups of children in schools, the researchers report on many aspects of life in their community.

The authors find that this community is rich in all the means ordinarily thought of as contributory to mental health. Yet their evidence which included the results of an objective test the California Personality Inventory would, in their words, "seem to point toward no better mental health, or perhaps worse, among children in this community compared with some others elsewhere."

CHILD PLACEMENT THROUGH CLINICALLY ORIENTED CASEWORK. Esther Glickman. Columbia University Press, New York. 1957. 418 pp. $5.75.

This comprehensive study of child-placing techniques and the philosophy that governs them developed out of institutes on child placement held by the author in various parts of the country. The first techniques discussed are those used by the child-placing agency's intake worker as he studies child and parents in an effort to find out whether separation is inevitable, and, if it is, to lay a groundwork for a break that will cause the least possible scarring. The author then sets forth diagnostic categories of parents whose children come to the attention of placement agencies, and describes various types of placement facilities. She devotes a chapter to techniques used by the caseworker in preparing child and parents for the placement, and another to those used in preparing the foster family.

Throughout the book the author emphasizes the necessity of learning the special nature and needs of the child, his parents, and the foster parents. She also stresses the importance of continued casework with the child in foster care and his parents, describing techniques for this phase of service. Finally she presents suggestions to the caseworker on meeting the problems that arise when the child is about to return home.

PROJECTS AND PROGRESS

New Chief Takes Office

Mrs. Katherine Brownell Oettinger, fifth chief of the Children's Bureau in its 45-year history, took the oath of office in ceremonies at the Department of Health, Education, and Welfare on May 17, 1957.

Secretary Marion B. Folsom, in administering the oath, said the Department was "very fortunate that Mrs. Oettinger was able to accept the position" and described the Children's Bureau as "unique in its history, its background, and its tradition."

Mrs. Oettinger replied, "It is a great challenge to link the progress of the past of the Children's Bureau with its future promise. I am joining with others interested in the welfare of children and will work with them in the genuinely inspiring opportunity to meet the needs of children wherever they are."

Later Mrs. Oettinger said:

"This is a time of exciting possibilities for improving the health and welfare of children. . . .

"Census estimates show we will reach a new production frontier within the next decade. By 1965, the number of children under 18 years of age will reach 67 million.

"We will then have more children than there were people in the country in 1890. Even now, our 56 million children under 18 represent a third of this Nation's population.

"Philosophically, I can state my enduring faith in the coming generation. Practically, I recognize that in a society made increasingly complex by almost daily discoveries and events, growing up today can be very difficult.

"We are living in a period of great and continual technical change.

"Early life choices for today's young men are influenced by the uncertainty of military service.

"The mobility of our population is altering community patterns. In 1954 alone, 10 million persons moved across State or county lines—3½ million of them children.

"A generation or two ago our challenge was the reduction of infant mortality. Today I think one of the greatest challenges we face is helping teenagers find their place in this changing world.

Katherine B. Oettinger

"Perhaps nothing is more illustrative of the complexities of today's society than the problems we face in trying to prevent and control juvenile delinquency.

"I am also acutely aware of two current trends with which the work of the Children's Bureau is vitally concerned.

"First, research, in all its ramifications, seems to be bearing more fruit today than ever before. . . .

"The Children's Bureau interest in research goes back to the founding of the Bureau in 1912, when Congress said it should investigate and report 'upon all matters pertaining to the welfare of children and child life among all classes of our people.' Research, I am sure, will be a major activity of the Children's Bureau in the future. . . .

"Secondly, there is a tremendous shortage of trained professional people in those fields which are concerned with the health and welfare of children. I hope that the Children's Bureau can move even further to strengthen its ties with the schools of medicine, social work, and public health, and with the social sciences, in their efforts to meet this really crucial need.

"I hope also that health and welfare agencies can be ingenious in drawing on the capacities of trained people who are not now at work. From my own experience I know how much citizens, acting in groups, can enrich services for children. It seems to me that parents—and I mean both mothers and fathers—can contribute more than ever as volunteers in health and welfare programs.

"I am also counting heavily on the warm cooperative relationship which the Children's Bureau traditionally has had with both public and voluntary agencies in fulfilling the tasks ahead. . . .

"It is my hope that we can always be vital and dynamic in meeting the truly significant challenges to prepare well for the future."

Mrs. Oettinger has had extensive training and experience in the fields of mental health, family service, and community organization. She has been dean of the School of Social Work, Boston University, since 1954. From 1950 to 1954 she was chief of the Division of Community Service, Bureau of Mental Health, Pennsylvania Department of Welfare. During those years she also helped develop advanced studies in community organization at the University of Pittsburgh.

For many years earlier she was consultant to the Visiting Nurse Association of Lackawanna County in Pennsylvania. She also served as a psychiatric social worker at a children's treatment center in Scranton, Pa. During those years, as chairman of the local committee on the care of children in wartime, she helped established day-care centers. Earlier in her career she had been employed in child-guidance and family-welfare work in New York City.

Mrs. Oettinger is a member of the National Association of Social Workers, the National Conference of Social Welfare, and the Council on Social Work Education, and is on the advisory committee of the American Child Guidance Foundation. She has served on the board of directors of the Massachusetts Association for Mental Health and of the Massachusetts Society for Crippled Children.

A native of Nyack, N. Y., she studied at Smith College and later received her master's degree in social work from the Smith College School of Social Work. She and her husband, Malcolm Oettinger, have two sons, Malcolm, Jr., and John.

Juvenile Delinquency

Services to groups of hard to reach young people were discussed by some 200 persons from 22 States at a conference held at Washington May 14-17, 1957, under the sponsorship of the Children's Bureau, the National Association of Social Workers, the National Social Welfare Assembly, and the United Community Funds and Councils of America.

The conferees included groupworkers, groupwork supervisors, and social-welfare agency executives, in addition to persons from welfare planning councils, schools of social work, the clergy, police departments, juvenile courts, State departments of public welfare, and housing authorities.

Only informal recommendations were made, one of which asked the Children's Bureau to pay special attention to programs for occasionally delinquent groups of young people. Other recommendations urged the Bureau and the other agencies sponsoring the conference: (1) to work systematically to solve the problem of professional relationships between police and social workers and to press toward formation of mechanisms to help those two groups reach better understanding; (2) to take leadership in determining how practice in providing services to groups of hard-to-reach young people is being documented and to make the documents available; and (3) to consider ways of testing the effectiveness of such services.

Adoptions

Representatives of public and private adoption agencies, maternity homes, councils of social agencies, and hospital medical social workers from 17 States met in Washington for 2½ days late in May for a Conference on Unprotected Adoptions called together by the Children's Bureau. Purpose of the meeting was to develop material for use in a statement on the role of the social worker and agency in adoption.

The discussants emphasized the fact that any adoption involves a series of decisions and the need for special skills in helping the child's natural parent or parents, the child, and the adoptive applicants. They pointed out that while the culmination of the adoption process rests with the court, it is preceded by many social and emotional problems calling for the skilled service of social workers. They designated the social agency as the logical meeting ground for the various professional judgments needed in the adoption process—medical, legal, and social—and pointed out that it carries a continuing responsibility and is accountable to the community.

A formal statement based on these discussions, will be published by the Bureau.

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New York City's Department of Welfare has a new adoption program which placed its first child in an adoption home in January of this year. First public program of its kind in the city, it was established to supplement the adoption efforts of local private agencies and as a complement to the foster-home program which the Department has been operating since 1949. The latter had 530 children in care in January, 60 of whom were reported to be potentially adoptable, the majority of them Protestant Negro children. Altogether that same month the city was paying for the care of some 16,000 children in foster homes and institutions, most of them placed there by private agencies.

Health Survey

About 3,000 householders a month are being visited by interviewers to obtain information for the National Health Survey, which is expected to provide the facts on health conditions throughout the United States to the Public Health Service, Department of Health, Education, and Welfare. The survey is a continuing project and was authorized by the 84th Congress at its 2d session.

The information collected will include data on the number, age, sex, and other characteristics of adults and children suffering from diseases, injuries, or handicapping conditions; the length of time that these persons have been prevented from carrying on their usual activities; and the amount of medical and dental care that they have received.

Statistics will be compiled both for the Nation as a whole and for each of 11 geographic regions. Data from these regions will be grouped by large metropolitan areas, other urban areas, and rural areas. In addition, statistics will be compiled separately for each of eight metropolitan areas that had population of more than 2,000,000 in 1950: New York, Chicago, Los Angeles, Philadelphia, Detroit, San Francisco, Boston, and Pittsburgh.

The household interviewing, which is being carried on in sample areas in every State, is being conducted for the Public Health Service by the Bureau of the Census, Department of Commerce.

International

More trained pediatricians may become available in a few years for the now understaffed maternal and child-health programs in countries aided by the United Nations Children's Fund (UNICEF). The increase is the goal of a decision of the UNICEF Executive Board, at a meeting in April, to extend its training program to physicians in order to help countries establish or strengthen departments of pediatrics in medical schools. The first allocation under the policy was $38,000 to Madras Medical College, Madras, India, to help this already well-established center for pediatric teaching to put greater emphasis on training teachers of pediatrics. Altogether UNICEF expects to spend not more than $500,000 on the pediatrics-training program.

At the same meeting the Board allocated funds for: preventing goiter among children in northern India; training Uganda village mothers in child care; and strengthening training and demonstration facilities for the care of handicapped children in Indonesia and Yugoslavia.

The total amount allocated at the spring meeting was $8,004,800, to aid 41 health programs in 35 countries. For these programs the governments of the countries to be aided have committed $24,510,000, about three times the amount allocated by UNICEF. Further allocations will be made in the fall.

More than half of the recent UNICEF allocation is for control of disease—malaria, tuberculosis, yaws, and leprosy.

including the cost of producing penicillin; about one-fourth is for maternal and child-health services, especially in rural areas; about a sixth for nutrition projects, including drying and pasteurizing milk.

The largest single allocation is $1,571,000, to supply insecticides and sprayers for the second year of Mexico's malaria-eradication campaign. Next in size is $1,515,000 to provide clinic and hospital equipment, vehicles, and training supplies to expand rural health services in India.

The Fund's Executive Director forecasts that more than 45 million children and mothers will be reached with UNICEF assistance in 1957, a 50-percent increase over the number benefited in 1956. This estimate includes an anticipated rise in beneficiaries of anti-malaria work—from 8 million in 1956 to over 28 million in 1957.

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The International Social Service has added eight social workers to its staff in Austria to interview each of the 2,000 unaccompanied Hungarian teen-agers under 18 there. The purpose will be to try to find the best plan for resettlement or for helping the youngsters to rejoin their parents. Temporary staff is being added to the 188 branches in France and Italy to carry out a similar program for the 700 unaccompanied teen-aged Hungarian refugees in those countries.

Child Development

Babies previously cared for by constantly changing institutional personnel became more responsive socially when one person took over their care as a part of two controlled experiments carried out recently in a Chicago hospital. At the beginning of each experiment four babies, ranging in age from 5 to 7 months, who until then had been tended under the usual hospital routine by a variety of women, were put under the sole care of one person, the experimenter, for 8 weeks. At the same time four other babies, the control group, continued under the normal hospital routine. An examiner, who was not the experimenter, gave each baby a battery of tests before the experiment began and at biweekly intervals during the experimental period and the following 4 weeks.

The results showed that the babies cared for by one person became more socially responsive not only to her but also to strangers than did those tended by a number of persons.

However, according to the experimenter, the chief mechanism in this change may not have been the caretaking per se, but rather "the frequent, active, and usually playful interchanges of attention between experimenter and baby."

Carried out by Harriet Lange Rheingold, the study is reported on in a monograph, "The Modification of Social Responsiveness in Institutional Babies," published by the Society for Research in Child Development, Inc., Purdue University, Lafayette, Ind.

Child Welfare

Children in 30 percent more counties in the United States had public child-welfare services available to them in 1956 than in 1946, according to information received by the Children's Bureau. The number of workers employed full time in professional positions in public child-welfare programs throughout the country increased by 82 percent between 1946 and 1956. Twenty-eight percent of all public child-welfare employees in 1955 had full professional training in social work; in 1950 only 19 percent had such training.

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Public welfare agencies were providing child-welfare casework services to 295,678 children on December 31, 1956, according to reports from State departments of public welfare. The largest proportion of these children (44 percent) were living in foster-family homes; the next largest (40 percent), in the homes of parents or relatives. The rest were living in public or private institutions, maternity homes, boarding schools, or hospitals, or had independent living arrangements.

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Staff losses of professional employees in child-welfare and voluntary family-service agencies are being studied by the Children's Bureau in collaboration with the Child Welfare League of America and the Family Service Association of America. The information-gathering phase of the study began on May 1, 1957, and will extend through April 30, 1958. During this period whenever a professional staff member resigns from an agency, the employer and the employee fill out different questionnaires, each giving the reasons for the employee's resignation and information on his education, work record, and new employment. The employee is asked whether or not he intends to return to social work.

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Florida's State Welfare Board recently established a five-member advisory committee of juvenile-court judges. It consists of two judges from counties having separate juvenile courts, two who also serve as county judges, and the president of the Florida Council of Juvenile Court Judges. The committee is to last for 2 years, after which the State welfare board will determine whether it should be continued. It is to meet 3 or 4 times a year, with Federal child-welfare-services funds being used for transportation costs and per diem pay.

Research

The University of Michigan is currently carrying on 14 research projects financed by funds appropriated by the State legislature, 5 of them directly concerned with children.

One project is collecting data on individual differences among severely retarded children, in an effort to reach the kind of understanding of such differences which can lead to: (1) the provision of a wider range of learning experiences for such children; (2) a reduction of the number of children receiving or awaiting State care for this type of handicap; and (3) a clearer distinction between children who need institutional care and those who can be prepared to take their place in the community.

In another project research workers are studying the value of camp experience to emotionally disturbed children.

In another the university, in collaboration with the State department of social welfare, is studying ways of motivating families receiving funds under the aid-to-dependent children program to improve their daily living and become more self-sustaining. An in-service training program to help ADC workers develop this kind of motivation in families is being evaluated as part of the project.

In a project concerned with congenital hypothyroidism (cretinism), the university is working on problems related to this defect in the fetus and newborn. The hope is to find ways of recognizing the condition in infants im-

mediately after birth, so that treatment can be begun at a time when it can be effective.

In another project research workers are constructing tests to distinguish children with aphasia from children whose language retardation is caused by emotional disturbance, brain injury, thyroid deficiency or mental deficiency.

The university plans to add a number of new projects during this fiscal year, including: research on such subjects as the relation between juvenile delinquency and school dropouts; moral values among adolescents; oxygen needs of newborn babies; conservation and development of talented high-school graduates; and growth and development of gifted children.

Maternity Care

Faced with the fact that the incidence of prematurity and the neonatal and maternal mortality in California's county hospitals have been much higher than in its private hospitals, the State department of health, on the recommendation of the State advisory committee on maternal and child health, is taking a number of measures toward improving prenatal care for women delivered in county hospitals.

A statewide study of the prenatal care given such women by local health departments and county hospitals, made in 1954–56 by the State department of health and the State conference of local health officers, showed that much of the care fell short of criteria for good care and that the policies concerning eligibility for prenatal care at public expense varied widely, were sometimes unfair, and often were not set forth in written form.

The State advisory committee, which represents many of California's public and voluntary organizations and agencies, recently reviewed the study findings and made a number of recommendations, including the following:

1. That the State department of public health, in cooperation with the groups represented on the advisory committee, develop standards and recommendations for good prenatal care and that it provide consultant teams to help local departments that wish to improve their services.

2. That all policies concerning eligibility for prenatal care at public expense be made known to the communities and professional personnel serving the families concerned, and that consideration be given to developing statewide basic policies concerning eligibility for such care and for hospitalizing women with complications of pregnancy.

3. That local health departments find out if they do not know the extent of deficiency in the prenatal care given in their communities, and the reasons why certain mothers do not seek, or do not obtain, adequate care; and that the local departments use this information in planning improvement of the service.

The State department of health points out that the lack of prenatal care given to low-income mothers is a serious public-health problem. In 1955, the department reports, the prematurity rate in the county hospitals was 50 percent higher than that in the private hospitals; also that the neonatal death rate among infants born in the county hospitals was 60 percent higher than the rate in the private hospitals, and the maternal death rate was 200 percent higher.

Vital Statistics

Information from the National Office of Vital Statistics, Department of Health, Education, and Welfare, indicates:

The maternal mortality rate (estimated) reached a new low in 1955: 3.8 deaths per 10,000 live births—a reduction of 76 percent from the rate for 1946. An estimated 1,570 women died in 1956 from causes connected with childbearing.

The United States birth rate for the first 4 months of 1957 was 24.2 per 1,000 population, a rate slightly higher than the rate for the corresponding months of 1956. In 1956 births exceeded 4 million for the third year in succession. From 1950 through 1956 about 27¾ million babies were born—substantially more than were born in the decade 1930–39 and almost as many as in 1940–49.

Marriages in the United States in 1956 amounted to 1,569,000, or 9.4 per 1,000 population, according to a provisional estimate; the rate for 1955 was 9.3.

The provisional estimate of the number of divorces in 1956, 377,000, was practically the same as in 1955; the rate in each year was 2.3 per 1,000 population.

The 1955 death rate for children 1–14 years of age, 69.6 deaths per 100,000 children, was 4 percent lower than the 1954 rate. The rate from accidents was 24.4 per 100,000; from cancer, 8.3; from influenza and pneumonia, 6.5; from congenital malformations, 5.8.

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The perinatal mortality rate for the United States was reduced by 11 percent during the 5-year period 1949–54, according to estimates by the Children's Bureau based on information collected by NOVS. "Perinatal mortality," as the term is used here, includes fetal deaths before or during birth in pregnancies of 20 or more weeks duration and deaths of infants within 28 days following birth.

The United States rate for 1954 was 35.9 perinatal deaths per 1,000 births (live and still). Reduction in the rate during that 5-year period was about the same for white and nonwhite infants, but the rate continued to be higher for the nonwhite. In 1954 the rate for the white group was 32.8; for the nonwhite, 51.3.

In 1954 among the 11 United States cities having 20,000 or more live births, Los Angeles and Chicago had the lowest perinatal mortality rates, 34.0 and 35.5; Pittsburgh's rate was slightly higher than the rate for the country as a whole, 36.4; and eight cities had rates considerably higher: Houston, Baltimore, Detroit, Cleveland, Washington, St. Louis, Philadelphia, and New York.

Facts and Figures

Of the more than 190,000 physicians in active practice listed in the 1956 American Medical Directory 3.7 percent limit their practice to obstetrics or gynecology, or both, and 3.4 percent limit theirs to pediatrics. Somewhat more than half of the former group are certified by the American Board of Obstetrics and Gynecology, and more than two-thirds of the latter by the American Board of Pediatrics. One-third of all the physicians listed are general practioners.

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Twelve percent of the drug addicts in the United States are under 21 years old, according to an estimate by the Bureau of Narcotics, U. S. Department of the Treasury, based on reports received during the calendar years 1953, 1954, 1955, and 1956. Of the 35,835 addicts reported, 4,403 were under the age of 21.

READERS' EXCHANGE

MARKOFF: *School drop-outs*

I concur heartily with the principle in Sol Markoff's article, "Youth and Work" (CHILDREN, March–April 1957) that an appropriate work experience can be a positive factor in the healthy development of the teen-age boy and girl, and with the frank concession that child-labor laws ". . . can and should be reviewed periodically and, if necessary, changed to meet the needs of the present in line with . . . our ever-expanding knowledge about what young people require for wholesome development."

We here at the New York City Youth Board were disappointed that Mr. Markoff's article did not deal more deeply with the special employment problems of the school "drop-outs." Also, while we would agree that employment, either part or full time, "will not perform miracles" nor ". . . 'cure' the juvenile delinquent," we think it is misleading to give the impression that there may not be some correlation between adolescent idleness and delinquency.

Recently the New York City Youth Board created a committee on jobs and rehabilitation for youth and asked that it address itself to the vocational-counseling, job-placement, and training needs of "hard-to-place" youth between the ages of 16 and 21 years and the working out of a comprehensive, coordinated plan for providing adequate services to this group.

By "hard-to-place" is meant the post-adolescent or young adult whose aggressive and restless behavior may be expressed in overt asocial or antisocial behavior and whose background and environment show evidence of high social pathology. Although young people of this type have usually had little formal education, training, or special skills, they are by no means all intellectually limited or retarded. However, they usually find it hard to relate to authority and consequently rarely last more than a few weeks on any job. There are few adequate job or training opportunities for them.

The committee has involved the cooperation of the vocational-counseling agencies, public and private employment agencies, minority-group organizations, and representatives of major trade unions and business concerns in New York City. Through its various subcommittees it has been exploring the extent to which impending military service affects the attitudes and plans of such young people; and has also been concerning itself with those parts of the child-labor and school-attendance laws which most affect the job placeability and work opportunities available to the "hard-to-place" group.

Presently the committee is working on two project proposals. One would provide for a special mobile vocational-counseling and job-placement unit for out-of-school youngsters in high-delinquency areas of the city. The second envisions the establishment in the secondary schools of a special 2-year pre-employment instruction course for potential "drop-outs."

Ralph W. Whelan
Executive Director, New York City Youth Board

SENN: *Objective tools needed*

Dr. Senn points out that current research on child development tends toward study of the biological equipment of the newborn and of broad social subcultural influences. ("Fads and Facts as the Bases of Child-Care Practices," by Milton J. E. Senn, CHILDREN, March–April 1957.) Indeed, the child as a complex biologic system in a complex field of forces is rapidly becoming a prominent theoretical model. The consequence is an emphasis on *individuality*. This view contrasts sharply with the "nickel-in-the-slot" concept of child behavior still prevalent in some psychological camps and the hydraulic concepts of some of the older psychoanalytic schools. Both of these ways of considering the child oversold the idea of similarity and regularity of pattern from child to child.

Because of current emphases on *individuality*, and on unpredictability, are we getting ourselves into an untenable position with respect to both prediction and treatment or guidance? Here, too, we may be intellectually subject to the fashions of an unsure age, beset by the insecurities of a world shaken to its foundation morally, and spiritually.

Perhaps it should not be surprising that folklore still plays a prominent part in our popular literature. The entire field of scientific child study is scarcely a half century old; yet within a generation the education of children has been completely remade by the intelligence test and the concept of individuality to which it led.

In personality study we have as yet not fashioned the instruments to objectify our concepts. Consequently we talk much in terms which have no precise referents. The world of parents-in-action is not helped much by such terms. Teachers as well as parents thus fall back on folklore, which after all has a strong empirical, pragmatic core. As social scientists develop concepts which can be related to objective tools, the literature of application will pick them up and put them to use.

Dale B. Harris
Director, Institute of Child Welfare, University of Minnesota

HOFSTEIN: *Confusing to novitiates*

In Saul Hofstein's able article on "Social Factors in Assessing Treatability in Child Guidance" (CHILDREN, March–April 1957), the needy child is seen as the center of such an intricate network of relationships that one wonders how any disentanglement can take place. That children do get help in their various kinds of dysfunctioning is a tribute to the skill of those who work with the threads. The parents of these children, if they read this article, might feel discouraged and wonder if the child remains an entity in this mesh of concepts and services.

To know the complexities of mental-health service is important for the sophisticated practitioner. For the novitiate in the field, as well as for the parent, there is need for reassurance that in spite of the web, the child does not get lost.

Helen Ross
Survey of Psychoanalytic Education, New York

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

THE SPECIAL MILK PROGRAM FOR SUMMER CAMPS AND SIMILAR CHILD-CARE INSTITUTIONS. Department of Agriculture, Agricultural Marketing Service. 1957. 6 pp. Single copies available from Agricultural Marketing Service without charge.

Addressed mainly to sponsors of nonprofit camps and child-care institutions, this folder describes the special milk program that the Agricultural Marketing Service administers, and tells, for each State, where sponsors should apply in order to take part in the program.

BEHAVIOR OF YOUNG CHILDREN UNDER SIMULATED REFRIGERATOR ENTRAPMENT: a study of children's reaction to and ability to use mechanical devices provided for their safety. Prepared by Children's Bureau and National Bureau of Standards with the cooperation of National Electrical Manufacturers Association. Department of Commerce, National Bureau of Standards. 1957. 20 pp. Single copies from the National Bureau of Standards without charge.

This publication reports on a 90-day study made as part of an effort to develop standards for a device to enable a young child trapped in a refrigerator to release himself. The investigators used a playhouse the size of a refrigerator for studying the behavior of each of 201 children when closed in. The behavior varied widely, but more children pushed at the door than did anything else, and when the door was of a push type such efforts were often successful. All the children were between 2 and 5 years of age.

CHILD WELFARE SERVICES: how they help children and their parents. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 359. 1957. 94 pp. 35 cents.

This publication is described more fully in the present issue of CHILDREN, pages 152-154.

CRIPPLED CHILDREN'S SERVICES AT THE MID-DECADE: statistical highlights of children receiving physician's services under the crippled children's program in 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 35. 1957. 16 pp. Single copies available from the Bureau without charge.

This bulletin shows graphically the rise between 1937 and 1955 in the number of children served under State-Federal crippled children's programs and the rate served per 1,000 children in the United States.

MATERNAL AND CHILD HEALTH SERVICES IN 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 38. 1957. 15 pp. Single copies available from the Bureau without charge.

Little change between 1954 and 1955 occurred in the volume of health services for mothers and children, according to this report. One type of service that rose to a new high level was public-health nursing. Other types of services reported include medical services, dental inspections, immunizations, midwife supervision, and classes for parents.

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Mother and child. When there is no father in the picture the mother's crucial decision on whether or not to keep her baby must be made at a time of deep emotional turmoil. Some of the factors entering into some unmarried mothers' plans for their babies and for themselves are described in the Connecticut study of medical and social services to unmarried mothers described on pages 174–180.

◀ *the authors*

Ever since he took his present job at the Jackson Memorial Laboratory in 1945 J. P. Scott has been studying the effects of heredity and early experience on the social behavior of dogs. One-time Rhodes Scholar at Oxford with a Ph. D. from the University of Chicago, he was for 10 years chairman of the zoology department at Wabash College. His recently completed book on animal behavior will soon be published by the University of Chicago Press.

Born and educated in the law in Vienna, Otto Pollak studied social work and sociology at Bryn Mawr College and the University of Pennsylvania after coming to this country in 1938. Currently he serves as research consultant to the Family Service of Philadelphia in addition to carrying out his responsibilities at the university.

Before going to Connecticut Hester Curtis (left) was regional medical director for the Children's Bureau at Kansas City and New York successively. She has also been State director of maternal and child health in New Mexico and West Virginia. Alberta deRongé (right) worked in family and children's agencies in New York before turning to the medical field as a member of the social-work staff of McCook Memorial Hospital in Hartford.

Before coming to the Children's Bureau over a year ago Rudolph P. Hormuth was assistant to the executive director of the Association for the Help of Retarded Children, a statewide organization in New York. Previously, as social-work supervisor at the Jewish Hospital in Brooklyn he helped establish a clinic for the mentally retarded.

Chiefly interested in the relationship between personality and social attitudes, Elizabeth Donvan has been at the University of Michigan's Survey Research Center since 1950. A graduate of Vassar College, with a Ph. D. from Michigan, she is currently working on a book reporting on the two studies of adolescents here described.

Education for parent education is a major focus of Aline Auerbach's attention at the Child Study Association, where she is in charge of a series of demonstration programs for training various types of professional workers for leadership of parent groups. Her latest pamphlet for parents is "The How and Why of Discipline."

Experiments on the effects of early upbringing on dogs suggest some comparisons between . . .

ANIMAL AND HUMAN CHILDREN

J. P. SCOTT, Ph. D.

Chairman, Division of Behavior Studies, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine

SEVERAL YEARS AGO my wife and I rented a small Indiana farm, with 6 acres of pasture-land which immediately started to grow up in weeds. Something had to be done and we bought some sheep in place of lawnmowers. About the same time a neighbor of ours gave us an orphan lamb which we raised on a bottle and kept in the house for the first 10 days of its life. Then we put it out in a shed in the same field as the other sheep. It went up to them once or twice but the mothers butted it away when it came near, and it soon lost interest. We kept on feeding it, and it grew up to be a most unsheep-like sheep. It never followed the flock but grazed around the field in its own rhythm. Instead of being afraid of people it ran up to us whenever we came around. Three years later it was still fearless and independent of its own kind. We concluded that Freud was certainly right about the importance of early experience, for a 10-day period of isolation had changed what appear to be some of the most important characteristics of sheep, their timidity and lack of independence.[1]

This type of observation illustrates one of the important uses for studies of animal behavior—the production of new and stimulating ideas about our own actions. When we see how thoroughly early experience affects behavior of an orphan lamb, we immediately wonder: "What if this should also be true of human beings?" Of course, such ideas must be viewed with caution. It is incorrect to reason by analogy and say that because a thing is true of a sheep or a rat, it must also be true of human beings. Watching the behavior of animals gives us ideas about human beings, but these are only ideas, not conclusions. Their truth can only be established by direct observation and experiment on people.

A more important result of studying animal behavior is that it produces general laws. If we find that a thing happens in a large number of different kinds of animals, particularly those which are closely related to human beings, we can be reasonably sure that the same thing will be found in human behavior. The behavior of the lamb is an example.

For many years scientists have experimented with taking the young of animals away from their own kind and rearing them by hand. This is particularly easy to do with birds, whose eggs can be taken and hatched in an incubator. The Viennese Konrad Lorenz dramatically describes what happens in the case of the eggs of the wild graylag goose.[2] The newly hatched goslings will follow any moving object, even a man. Once they begin to do this, it is very difficult to get them to follow anything else, even an adult of their own kind.

Lorenz has also experimented with jackdaws, which develop much more slowly than geese. When artificially reared jackdaws are put back later with their own kind, they act a good deal like a lamb reared away from its own flock. They are attached to people rather than jackdaws, and are not afraid of dangers which jackdaws normally avoid.

Much the same thing happens to the puppies, birds, and kittens that we bring into our homes as pets. Taken away from their mothers they become attached to people.

At the Jackson Laboratory we have studied the social development of hundreds of puppies as they grow up with their mothers and littermates and are

trained by human attendants. We tried to find out as much about them as Gesell did about humans.

Very soon certain new facts began to emerge. The social development of the puppy can be divided into definite periods based on the beginning and end of important social relationships. At birth the puppy is both blind and deaf, and its needs for food and elimination are taken care of by reflexes. It grows larger and stronger in the next few days but there is no evidence that it learns anything in this neonatal period. Then on the 10th day the eyes open and the transition period begins. Within the next week or 10 days the puppy's whole behavior is transformed. At about 3 weeks of age, when the metamorphosis is nearly complete, the puppy begins to pay attention to the human observer. This is the first time when the development of a true social relationship can be observed. For the next few weeks the puppy can be taken from the mother and easily socialized to human beings. Doing it before this time has little or no effect, and doing it later becomes increasingly difficult. Obviously, these weeks are a critical period in the development of social relationships.

We then went back to the puppies and studied them more intensively. Dr. Fuller and his colleagues found that there is no evidence of conditioning or simple memory before 3 weeks of age.[3, 4] The newborn puppy shows almost no brain waves as measured by the electroencephalograph and no differentiation between the waking and sleeping states. At 3 weeks there is a profound change in brain waves and differentiation between sleeping and waking.

It looks as if the puppy in its early days is highly protected from the external environment, so that socialization can only take place after a certain degree of maturity is achieved. This raises a question concerning early human development. Is the human infant more like the sheep, in which the critical period for future social relationships occurs within 10 days after birth, or more like the dog, for whom the critical period occurs sometime later? Obviously, if we had this information we would be in a position to make recommendations of fundamental importance regarding early child care and the time for adoption.

The evidence from puppies and many other animals shows that all social animals have a relatively short period early in life when positive social relationships are established with members of their own kind and after which it becomes difficult or impossible to establish them. This is the process of primary socialization, and because it is so widespread in the animal kingdom we have every reason to expect that it exists in some form in human beings. If so, it is a very important period in human development, determining the particular people with whom a child will find a close emotional attraction, and possibly limiting the kind of people with whom he can develop similar relationships later on.[5]

A School for Dogs

There is still another use for animal experiments. We can take an idea which has been developed through experience with children and test it experimentally by setting up an analogous situation with another animal. This was the idea behind the Jackson Laboratory School for Dogs.

Every professional person who works with human beings is impressed by individual differences. Doctors find that one patient who has suffered from a broken home during early childhood develops a neurosis, while another similarly deprived becomes an effective human being. Are such differences caused by heredity or environment or a combination of both? These questions can be tested experimentally in animals.

Since the various dog breeds have been selected for differences in such temperamental qualities as aggressiveness and abilities to learn, and such different occupations as hunting rabbits and herding sheep, it should be possible to set up a uniform system of care and training and subject various types of dogs to it. Most of the differences should then be due to heredity. At Jackson we found that the different breeds did indeed react differently to the same tests, albeit with considerable individual variability due to minor environmental differences.

With all this background information we had an excellent opportunity for trying out various experiments in interfering with the normal process of socialization in puppies.

Our first experiment was a drastic one—to cut out all the puppies' contacts with people. We placed a mother in a large field surrounded by a 7-foot board fence. When her puppies were born no human contact was permitted except for the bringing in of food supplies by the experimenter, which he did as rapidly as possible without paying any attention to the pups. Under these conditions the puppies, instead of becoming tamer during the period of socialization, became wilder and wilder, until by the age of 3 months they were almost like wild animals, running away from human beings on sight. If finally caught they showed signs of great fear and desperately struggled

to bite and get away. Such puppies can be tamed by the same method used for wild animals—confinement, handling, and hand feeding. Even so, they are always somewhat timid around human beings and never as trustworthy as normal dogs.[6]

The opposite experiment is to take a puppy away from its mother for the period of socialization and rear it entirely with people. Such pups form very strong attachments to people and become the type of dog which we call "almost human." Their social relationships are almost entirely with people and they have very little use for other dogs. We have not done this experiment with many animals, so that we are not able to say what the adjustment of such dogs to other dogs might be. It probably depends a great deal on whether the dogs react in an aggressive or friendly manner. In one case a puppy reared with human beings was at 9 weeks placed back with other dogs. These were relatively peaceful animals, and after some initial fearfulness the puppy seemed to become adjusted to them. When such experiments have been done with birds the results have sometimes been very dramatic, the birds refusing to mate with their own species. When wild animals, such as fawns, are raised in this way, they are rarely able to adjust to their own kind.

Another experiment is to raise puppies in isolation during the period of socialization, so that they have no contacts with either people or other dogs. This has been done by Melzack and Thompson[7] at McGill University and also by Fisher[8] at our laboratory. The puppy is raised in a box which can be partitioned off so that food can be introduced without the puppy's seeing or touching the experimenters. Puppies develop physically in a normal way under these conditions. As might be expected, they are completely inexperienced for dealing with both the physical and social aspects of their environment when they are released from the box at 3 or 4 months of age. One striking result is the effect on their competitive activities.

Puppies normally reared together do a great deal of playful fighting with each other and thereby gradually establish a dominance system. If there is only one dish of food or one bone, the dominant puppy always takes it away from the subordinate one simply by growling and threatening. The isolated puppy has had no experience of this kind. When it sees other pups of its own age for the first time it simply stands still and looks at them. The normal puppies approach in an aggressive way, a fight usually ensues, and the isolated pup comes out

A scientist at the Jackson Memorial Laboratory tries to train two puppies to follow on a leash. The puppy at the left, which after many trials is still putting up a stiff resistance, was brought up in a field without human contact. The puppy on the right, following along happily, has had close contact with human beings since he first opened his eyes.

at the bottom of the dominance order. Fisher put four isolated fox terriers together at 4 months of age, and they lived together without fighting for many weeks and never developed a dominance order. On the other hand, groups of fox terriers reared together usually fight a great deal.

Socialization and Training

All these experiments show that the lack of contact with others during the period of primary socialization produces drastic effects on behavior. The animal whose contacts have been limited in this early period is correspondingly limited in his ability to develop social relationships at a later date. Of course, such experiments as this are never done on human children and never will be. We have to take what conclusions we can directly from the animal work. It is too early to say that all animal species would behave like the isolated dogs, but we can at least conclude that human contact in early life is an essential part of normal human development, and cannot be replaced by mechanical care, no matter how efficient the machine may be. We would also suspect that a considerable variety of pleasant contacts with relatives and strangers would be likely to produce a child who gets along well with strangers.

Once we know the general effects of socialization we can experiment with different types of training during this critical period. In our laboratory, Dr. Alan Fisher tried the effect of three kinds of training. The puppies were raised in isolation boxes and brought out for definite kinds of training, so that the experimenter knew exactly what kind of social experience each puppy got. In one, the puppies were simply played with and never hurt or trained in any way. In another, the puppies were sometimes played with and sometimes punished for any social contact with the experimenter, who deliberately tried to be inconsistent in his treatment of them. Still another group of puppies were slapped or shouted at every time they approached the experimenter. The three types of treatments correspond to the practices of parents who: (1) spoil the child; (2) are ambivalent in their attitude; or (3) completely reject their child.

The puppies were tested in a great many ways. As might be expected, the pups that were punished in any way were much more fearful of human beings than those which were spoiled. However, they did not stay away from them. In fact, the puppies which had been punished paid far more attention to the human handler than those which had not. Even those which were continually punished were strongly attached to human beings in spite of their bad treatment, and as soon as the punishment stopped became very friendly.

Such experiments require careful interpretation. In the first place, these puppies were fox terriers, a breed which has been selected for aggressiveness and the ability to take punishment while fighting. Punishment has a far different effect on a more sensitive animal, such as a collie or sheep dog. However, we can conclude that this experiment explains why certain children can go through bad early experiences and come out relatively unharmed. Human temperaments which are as tough as those of the fox terrier, and which can take a great deal of punishment without damage, may well exist. The experiment also shows the very strong tendency of puppies during the period of socialization to form some sort of social attachment in spite of every possible discouragement. This fits human experience in that children who have been badly mistreated still become closely attached to their parents.

This experiment indicated that puppies behave very differently depending on whether they are punished or not in early life. Freedman set up an experiment which was designed to test this hypothesis more directly.[7] He worked with one group of puppies which he tried to spoil completely, and another which he trained through a system of reward and punishment to obey certain normal commands, such as to sit. He tried the experiment on several different dog breeds, including the aggressive fox terriers and breeds of other temperaments. As a test of the effect of training he set up a "conscience test." The puppies were brought into a room where there was a dish of food and punished if they tried to eat it. As soon as they had learned to stay away, the experimenter went out of the room and watched to see how long the puppies took to come back to steal the food in his absence.

The results showed the effects of heredity very strongly. None of the Shetland sheep dogs ever came back to touch the food, no matter how they had been treated before. The inhibitory training was complete in these sensitive animals. On the other hand, a strain of African basenjis, which are rather aloof in their relationships with human beings, had a strong tendency to come back to the food as soon as the experimenter left, whether they had been spoiled or trained.

There were two other breeds, aggressive fox terriers and nonaggressive beagles. In both, the dogs

which had been spoiled stayed away much longer than those which had been trained. The interpretation seems to be that to animals which had never been punished, the shock was so great they they were much more impressed by it than were those who had been punished before. We can conclude that the animals that have experienced punishment are much more able to take it and also disregard it, than those which have not.

These experiments can be analyzed in another way by asking: "What does the puppy learn from his experience?" A puppy which is allowed to do anything he wants to learns two things: that his behavior has no effect on that of the experimenter; and that the experimenter has no effect on his behavior. On the other hand, the puppy which is either punished inconsistently or punished all the time learns that the behavior of the experimenter affects him but that his own behavior has no effect on the experimenter, since he gets punished no matter what he does. Finally, the animal which is normally reared learns that, depending on what he does, his behavior may be either rewarded or punished by the experimenter. In other words, his own behavior affects that of the experimenter and determines the effect that the experimenter has on him. Such interaction is the essence of a normal and healthy social relationship between parent and child. Each responds to the behavior of the other and knows that his own behavior has some consequence. Presumably in this way the child learns the process of self-control.

Use of Punishment

These experiments also suggest certain things about the use of punishment. One is that punishment is most effective if applied seldom. In this connection we unwittingly did another experiment.

One of the drawbacks of punishment is that it stimulates rather than controls fighting. In our major experiment in the School for Dogs, we decided to avoid all punishment, as we wished the animals to be able to live together peacefully. All that we did to the puppies from a very early age was to pick them up and hold them while we made various observations and tests. The dogs became very submissive while being held, until all we had to do if we wanted to control them was to walk over and pick them up. As they saw us coming they would crouch down and become quiet. Obviously, restraint can achieve many of the results sought through punishment, without the bad side effects. Possibly the human habit of picking up children and holding them has similar effects, so that adults become highly dominant over their children.

Effects on Parents

So far I have described experiments which bear on the psychological development of children. However, we must always remember that the parent-child relationship is a two-way affair and that the behavior of children affects that of the mother as well as the other way around. Frederieson [10] discovered two strains of domestic mice which reacted differently to competition over food. Mice of the first strain always struggled actively for a small piece of food when they happened to be hungry, but those of the second strain ate peaceably side by side. Frederieson exchanged the offspring at birth, and after the young had begun to grow up tried the effect of competition again, this time between the parents and offspring. The competitive parents struggled for the food when hungry, but the behavior of the peaceable foster children was unchanged, and they did not struggle for the food. However, in the other situation, when the competitive foster children began taking food away from their peaceable parents, the parents began to struggle with them. Thus, the example of the parents did not affect the offspring, but the behavior of the offspring affected the parents.

The same principle applies to the process of primary socialization. Most experimenters have studied the way in which the young become attached to their parents and have paid little attention to the way in which parents become attached to their offspring. One of the most interesting experiments along this line was done by Collias with sheep.[11] He took young lambs away from their mothers and brought them back sometime later. If the lamb was brought back to its mother any time within 4 hours, or, indeed, if any other young lamb was brought during this time, she would accept it and allow it to nurse. Beyond this time she began to drive all lambs away. Apparently this is a very limited time during which the mother will form a social relationship. The reasons back of this are not yet understood, but they possibly have something to do with changes in the endocrine glands.

Human mothers, of course, do not react in precisely this way, and will form very close emotional ties to adopted children without ever having experienced pregnancy. However, the experiment suggests that there may be a time immediately after delivery when the human mother is in a highly im-

pressionable emotional condition, and that immediate contact with the baby might set up a powerful emotional bond. However, more experiments need to be done with animal mothers before we can understand the nature and importance of the formation of the parental half of the mother-child relationship.

Instinctive Reactions

I have described here only a few of the many types of animal experiments which are throwing new light on the problems of child rearing and the development of mentally healthy adults. The finding that in many of the lower animals, particularly birds, social reactions can be set off almost mechanically by special stimuli, called releasers, suggests that even human beings may harbor remnants of instinctive reactions.[12] For example, either the smile of a baby or its crying produces emotional reactions in most people. These may be more than learned reactions, although learning plays a part.[13]

Another group of experimenters have been interested in effects of handling. They find that merely picking up a young rat or mouse for a few minutes each day will cause it to learn better in later experiments, and even to gain weight faster.[14] Such results are no surprise to animal trainers, who know that the tamer an animal is the easier it is to train. This suggests that the normal process of socialization or forming an attachment to one's own species is also a matter of taming, and that children who are frequently handled will develop into healthier and better adjusted adults. It supports the observations of Spitz[15] that children raised in orphanages with little attention and handling tend to be unhealthy.

The results of animal experiments give promise that human child rearing may eventually develop into a more exact science. At the present time we can say definitely to a dog owner that if he allows puppies to grow up in a kennel without human handling, they will be timid and poorly adjusted to human beings in later life. We can also say that this handling will produce little or no effect if done before 3 weeks of age and will have its greatest effect if it is done between 3 and 7 weeks. In the long run, we would like to be able to give the same kind of exact advice to human mothers.

For example: It is practically impossible to spoil a very young baby. The more attention and care that a new baby gets the better he will develop. But at what age should we start letting a child do things for himself and encourage independence? This would probably differ for individual children, partly because some develop more rapidly than others and partly because children have different temperaments and demand different sorts of treatment. The highly sensitive child can probably take, indeed probably requires, a great deal more protection and indulgence than a tough, aggressive one.

We need to know not only the exact age of children but the landmarks in their development and ways of estimating their basic types of emotional response before we can do a really intelligent job of child rearing. Some of this needed knowledge must come from direct observations of children. Much progress is being made this way. On the other hand, many experiments can be done better on animals not only because they are shorter lived but also because their environment and heredity can be more exactly controlled. The next few years should produce exciting new discoveries in both directions.

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Some conceptual steps toward a theoretical framework for studying . . .

FAMILY SITUATIONS AND CHILD DEVELOPMENT

OTTO POLLAK, Ph. D.
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IN THE LAST DECADE the professional activities of family caseworkers and child-guidance practitioners have been significantly influenced and sometimes disturbed by various attempts to shift therapeutic attention from the individual to the family group. These attempts have come from psychiatrists such as Nathan W. Ackerman, Peter B. Neubauer, and Maurice F. Friend; social caseworkers such as Frances Levenson Beatman, Frances H. Scherz, and Martha Grossman; and sociologists such as Marjorie L. Behrens and myself. The movement has influenced practice through supervision, publications analyzing failures in therapy, experiments in family diagnosis and therapy, and some proposals of theoretical reformulation. It has not been a grassroots movement. The emphasis seems to have come from representatives of disciplines allied to social work or from administrators of social agencies. Apparently, it makes demands on practice which caseworkers and psychotherapists on the firing line find hard to meet.

Since I have already published two books on this subject[1,2] I feel some diffidence in expressing myself further on the progress thus far achieved. However, the fact that I have recently formulated a few additional thoughts which might be found helpful by both theoreticians and practitioners encourages me to present a summary of my work in this field up to date.

After being made available by Russell Sage Foundation in 1949 as consulting sociologist to the Jewish Board of Guardians, a multiple service agency with a child-welfare focus in New York, I attempted to carry out this responsibility until the spring of 1956 by pointing out or providing conceptual and other theoretical instruments to aid in broadening diagnostic perception and therapeutic planning. In the summer of 1956 I continued the work independently under a research grant (No. 948) from the University of Pennsylvania.

The history of these attempts has been marked by various phases. In the first, it was thought by my associates at the agency and by me that emphasis on a comprehensive situational approach and the incorporation of certain social-science concepts into the theory underlying clinical work in child-guidance practice would be sufficient to secure diagnostic and therapeutic consideration of the whole range of pathological factors which might determine the emotional and developmental difficulties of a child. The individual concepts suggested were the *family of orientation*, *social interaction*, *social role*, *socialization*, *culture conflict*, and *reinforcement* within the framework of stimulus-response learning. Specifically, we expected the concepts of *family of orientation* and *social interaction* to widen the scope of diagnostic inquiry and the range of persons considered for therapy. We expected the concepts of *culture conflict*, *social role*, and *socialization* to help in gearing the therapeutic goal more closely to societal expectations. Finally, we expected *reinforcement* to introduce a measure of activity and direction into the permissive atmosphere of psychotherapy.

Adapted from a paper presented at the 1957 forum of the National Conference on Social Welfare.

These thoughts were developed in a volume which I wrote in collaboration with the senior staff of the agency's child-guidance institute.[1] It is now my opinion that this book was written too early, because the propositions made in it were presented before being exposed to practice testing. We were at that time not able to show the many consequences which an application of some of the social-science concepts mentioned above would have for family diagnosis and family therapy. This was done only in the second phase of the project.

The Second Phase

In that phase we were engaged for 2 years in an experiment in which a clinical team with social-science representation tried to apply in practice the concepts and general orientation theoretically discussed in *Social Science and Psychotherapy for Children*. In the course of this experiment we found that our conceptual spadework had provided the basis for some very stimulating forays into the study of family situations affecting child welfare. However, during the preparation of the report on these clinical studies,[2] it became apparent that the original conceptualization would have to be supplemented by such additional concepts as *family dysfunction*, *association and dissociation*, *relationship tendency arrest*, and *relationship tendency reversal*.

In their time sequence, our clinical experimentation and the writing of the report would seem to represent two different phases of the project. Functionally, however, the period of practice testing and the period of writing should be regarded as a continuum because a meaningful formulation of our clinical work demanded the conceptualization which occurred only after the experimental team had ceased its operations.

At any rate, it seemed on the basis of this second phase that at least two dimensions of inquiry would have to be extended if a satisfactory understanding of the pathology of a family situation were to be achieved.

First we had to remain aware of the fact that the family, besides being an institution for the satisfaction of the present needs of its members, is anchored in the past of both parents and directed at the future of all its members. In other words, our understanding had to be extended to the families of orientation from which the parents came. This made the task of reaching a family diagnosis an undertaking based on the understanding of three families instead of one. It also made all siblings focal points of clinical concern, because every child had to be regarded as a potential parent in the next generation and thus as a potential carrier of family pathology. This meant that the range of our child-welfare concern could not be limited to the child referred by the parent, a selection which in itself might have been an expression of pathology.

Secondly, we had to recognize that the family group of interest in child-guidance work includes at least two interaction systems which are dynamically interdependent: the marital relationship and the relationship of parents and children. Both these systems have functions for their membership which are reflected in relationship tendencies of association and dissociation. These relationship tendencies need to be viewed both in short-run and long-run perspectives.

At first, after marriage, spouses normally go through an experience of increasing closeness. When children arrive this closeness is relaxed somewhat, setting the parents free emotionally and functionally for child care and rearing. Then, the relationship between parents and children also goes through a period of increasing closeness. This last is dramatically reflected in the development of the smiling response and later in the selective parent-child attachments which have become conceptualized as oedipal involvements. When children reach the latency period, however—and in our impatient culture sometimes earlier—they are started on the road of emancipation which although sporadically blocked by the vagaries of adolescence ultimately leads them into the emotional freedom necessary for marriage.

The compensatory connection between the association and dissociation tendencies in these two systems is apparent. In the long run, the pattern brings the spouses closer to one another as their marriage matures, thus enabling them to bear the emancipation of the children and, incidentally, the death of their own parents. In the short run, it brings them closer to one another at first, thus enabling them to complete their emancipation from their parents and making them emotionally ready to function as a child-rearing couple. Then, the growing closeness between parents and children in the first 5 years of each child's psychosexual development compensates for the temporary and moderate dissociation in the spouse relationship which child rearing demands.

The family diagnoses in our project seemed to demand, therefore, a clinical, genetic, and dynamic diagnosis of the intrapsychic discomforts of all the

members of each family group. They required an evaluation of the effects which the expressions of these discomforts had upon the performance of the family functions and upon the relationship tendencies in the two interactional systems within the family. In other words it seemed necessary in every study of a family situation to go through three phases: (1) psychiatric diagnosis of every family member; (2) analysis of the interaction patterns resulting from the effects on one another of the expressions by family members of their various intrapsychic discomforts; and (3) evaluation of the effects of these interaction patterns on the relationship tendencies and the functional performance of the family as a social institution.

The evaluation of the interaction patterns in a family and their results in terms of family functions and relationship tendencies may recommend itself to general family-welfare practice for two reasons. First, it relates the diagnosis and therapy of intrapsychic discomforts in individuals to the purpose of the family as a social mechanism for the satisfaction of the fulfillment needs of the marriage partners and the growth needs of the children. Secondly, it permits a differential evaluation of apparently similar discomforts in two persons as well as recognition of the same meaning of apparently different symptoms in another set of persons.

Some Cases

In one of our cases the parents showed different symptomatology. The father was diagnosed as suffering from a psychoneurotic disorder, mixed type, with phobic reactions, obsessive compulsive reactions, and depression. The mother, equally neurotic, had conversion symptoms. The son's diagnosis was the same as the father's. Thus we had differential diagnosis in regard to the spouses and concurrent diagnosis in regard to father and child.

In dynamic terms, we noted that the parents frustrated one another in exercising their mechanisms of defense. The father defended himself against feelings of insecurity by a strongly voiced attitude of superiority toward women and demanded to be catered to by them. The mother defended herself against her anxieties by striving for professional success and in this pursuit neglected her household. Thus in spite of different defenses husband and wife had the same marital problem. Because of the incompatibility of their neurotic defenses they frustrated one another and prevented the development of a relationship tendency which would have given them increasing closeness over the years. In their relationships with the boy, however, both father and mother engaged in overidentification. They projected their own feelings upon him and prevented him from achieving that measure of separation which his developmental needs demanded, so that he seemed imprisoned in parentally created inhibitions. This constellation seemed to the writer to permit the following family diagnosis: "Family dysfunction and relationship tendency reversal on a neurotic basis."[2]

In another case both parents and their three children seemed to share such a degree of separation anxiety that the family group resembled an emotional prison which handicapped freedom of movement on the part of all its members. In this case the father had conversion symptoms; the mother was obsessional; the oldest boy was a stutterer, had fears of high places and overconcern with cleanliness; the other boy had a severe rocking symptom; and the youngest child, a girl, also showed obsessive concern with cleanliness.

In respect to the spouse relationship, the parents satisfied their needs for intimacy and mutual support. In fact, they aided and abetted each other's defenses. By so doing, however, they locked one another in a relationship of mutual overdependence which irritated both. In relation to the children also, these parents reinforced one another in a severe separation anxiety, so that the children's dissociation tendencies were drastically discouraged. Thus we had a family whose pathology could be diagnosed as "partial family dysfunction with relationship tendency exaggeration between the spouses and relationship tendency arrest between the parents and children, based on a neurotic exploitation of both function and relationship."[2]

It was not always the *effect of defense upon defense*, however, which we found to determine functional performance and relationship tendencies in the family group. Occasionally, the concept of *social role*—the social expectation of a certain type of repetitious functional performance—seemed to offer useful conceptual equipment.

We had, for instance, a case in which the death of the mother had put upon every surviving member of the family incompatible social roles. Two sisters had to assume mother roles toward a much younger sibling. The father had to assume a partial husband role in relation to the child-rearing and homemaking functions of one of his two older daughters. The youngest of the three sisters had to assume a daughter role toward her brother-in-law, and so

forth. In that instance psychiatric diagnosis of each member of the family would not have been obtainable because of the attitudes of some of the persons involved. Role analysis, however, starting with Cottrell's theoretical proposition that "all personality systems are subject to internal stress due to the activity of contradictory roles,"[3] furnished a feasible approach to the formulation of a family diagnosis. This was conceptualized as: "family dysfunction due to multiplicity of incompatible social roles, resulting in relationship tendency reversal between the father and his two adult daughters, relationship tendency reversal between one of these daughters and her husband, and relationship tendency reversal between one of these daughters and her neurotic and defective sister."[2]

Personality Development

The work of our experimental team also included interesting experiences in the management of extrafamilial factors which promised either to obstruct or enhance therapy. Space is too limited here for describing this part of our efforts to achieve perceptual coverage of the complexity of social situations. However, I will report on a beginning of a transition from this enlargement of a dynamic understanding of a social situation to an enlargement of a dynamic understanding of personality development.

In the summer of 1956, I tried my hand at a number of theoretical reformulations which might be expected to facilitate perception of the plurality of factors operating in the course of child development. In this work I attempted to combine concepts of equal levels of abstraction only, and to shift from the utilization of concepts alone to the introduction of theorems.

In writing my report on the previous project, I had gained the impression that many of the difficulties which practitioners encountered in their attempts to cover the major factors in a social situation were due to misleading dichotomies, which seemed to act as perceptual traps, such as "the individual and his family" or "the individual and his environment." Such phrases combine a relatively concrete phenomenon, a person, with an abstraction, the family or the environment. As a result the practitioner's perception becomes anchored in the concrete and bypasses the abstract. In order to avoid this I decided to combine concepts referring to individuals only in constructing my theorems.

Secondly, I had to shift the nature of my theorems from probability statements to statements of possibility. Much confusion has been created among the representatives of various professional disciplines because the word "theorem" has been used in ways which are applicable to the nature of some disciplines but not of others. In the language of mathematics, a theorem designates a general principle capable of being proved to be *valid all the time*. In the sciences, natural as well as social, a theorem designates the *probability* of a connection between two phenomena. It suggests only that when one occurs the other is likely to occur also.

For this reason scientific theorems have an obvious place in the realm of action to prevent social ills. However, they do not have a similar place in curative efforts directed at the individual.

The notion of probability is based on large numbers. Where the individual case is the focus of concern the predictive power of probability statements does not furnish sufficient guidance to the therapist. He will not be able to base his decision purely on an actuarial expectation but will have to strive, even if only by trial and error, for a higher degree of certainty. He must remain concerned with *possibilities* as well as probabilities. For this reason, I believe that clinical perception can be served more satisfactorily by theorems which state connections between phenomena as possibilities and thus direct inquiry into channels which otherwise might remain unexplored. With this purpose in mind, I have evolved the following theorems of child development.

1. The Theorem of Family Model Combination

The insistence of the situational approach on the observation of multiple interaction patterns requires an elucidation of their functional significance. From the viewpoint of child welfare the interrelatedness of these patterns within a family must be viewed as a combination of developmental influences. Because of their effect on individual growth the significance of interaction between the father and the child and between siblings must be recognized as well as the significance of the mother-child relationship. This bearing of multiple interaction patterns on the development of personality traits in a growing child can be theoretically formulated in the following terms: *The experience of multiple interaction patterns among the members of his family provides a child with the opportunity for selective model combination.*

Therefore, the actual impact of a family situation upon the personality development of a child cannot be fully understood until all family members

and their interactions with the child and among themselves are considered.

2. The Theorem of the Family-Plus Factor

The theorem of family model combination can vastly enrich the potential of family study as a clue to the understanding of child development. However, the instrument of family study should be protected against the expectation that it will explain everything. In our society so many functions have been taken away from the family, so many experiences in other primary groups have been provided, and the impact of the representatives of the various child-focused professions upon growing individuals has become so strong, that personality-forming influences are no longer rooted entirely in the family. Theories of child development have tended to be oversimplified in terms of family influence.

In addition to the impact of social change upon opportunities of American children for contact with extrafamilial models, attention should be paid to the impact of behavioral experimentation on development. Such experimentation may produce rewarding experiences and, in consequence, contribute to the development of personality traits which cannot be traced either to familial or to extrafamilial models.

A perception-enhancing theorem taking these influences into account might be formulated this way: *A child's universe of model opportunities always exceeds the members of his family, and learning can occur through behavior experimentation as well as through the incorporation of model figures.*

3. The Theorem of Model Adaptation

It is a frequent clinical observation that children model their behavior after a parent but with some modifications. A modification may express itself either in a combination of traits taken from the parental model with those taken from other models, in an acceptance of the parental model with one significant omission, or in an acceptance of the parental model plus one trait not identifiable among any of the models available to the child. Therefore, on occasion, neither the theorem of family-model combination nor the theorem of the family-plus factor may furnish the dynamic reason for a specific development in a child.

Here ambivalence may be a key explanatory factor. No child can grow up without some ambivalence in his feelings for his parents or other persons significant to him. This ambivalence seems to express itself in an adaptation which makes up for the trait in the model which the child regards as a flaw. The formulation is therefore: *a child's adaptation of a model's traits is likely to have its dynamic cause in a dissatisfaction of the child with the person involved.*

4. The Common Destiny Theorem of Sibling Development

Emotional concordance, where it exists, is likely to be the result of a long development in intrafamilial interaction patterns. If its tone is negative in a family with children near the same age, it is unlikely that one will develop without difficulties while another will develop pathology. The danger that all siblings will be similarly affected by a negative emotional climate becomes evident when we recognize that negative emotions frequently make for poor role performance, cause the creation of socially inadequate defenses such as projection and displacement, and effect deviations from normal relationship tendencies. In reverse, positive emotional concordance is likely to strengthen the adequacy of role performance within the family, to permit the development of socially adequate defenses, and to keep interfamilial relationships within the normal tendencies. This engulfing quality of a homogeneous emotional climate in a family could be formulated as follows: *In families with emotional concordance the developmental patterns of siblings will tend to show similar degrees of health or pathology.*

The application of this theorem would require that where information suggests a preponderance of negative emotions in a family, therapeutic concern should be automatically extended to the siblings of the referred child.

In Summary

In these four theorems I have tried to spell out the implications of a belief in the importance of the total child-rearing situation upon personality development. Whether these theoretical reformulations will prove to be perception enhancing in diagnosis and therapy is, of course, subject to practice testing. The formulation cannot do more than set the basis for the test.

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[1] Pollak, Otto, et al.: Social science and psychotherapy for children. New York: Russell Sage Foundation, 1952.

[2] Pollak, Otto: Integrating sociological and psychoanalytic concepts: an exploration in child psychotherapy. New York: Russell Sage Foundation, 1956.

[3] Cottrell, Leonard S., Jr.: The analysis of situational fields in social psychology. American Sociological Review, June 1942.

How a study of illegitimacy in Connecticut has resulted in correlation of . . .

MEDICAL AND SOCIAL CARE FOR UNMARRIED MOTHERS

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DURING WORLD WAR II when the Connecticut State Department of Health was participating in the federally supported Emergency Maternity and Infant Care Program for the wives and infants of men in the Armed Forces, it found that many applicants for care were women and girls pregnant out of wedlock. Since the EMIC program could not legally be stretched to cover such applicants, the department assisted them through other Federal funds for maternal and child-health services.

After the war the department recognized the need for carrying a continuing responsibility for the health and well-being of illegitimately pregnant women and their babies. Late in 1948 the director of the bureau of maternal and child hygiene asked consideration by the committee on public health of the Connecticut State Medical Society of a program of medical and social care for unmarried mothers to be administered by the State department of health. The committee in turn asked for a comprehensive report from the department on what facilities were available in communities and in the State at large, "both for the sociological and medical care of unwed mothers during their pregnancy."[1]

A committee representative of social agencies, hospital administrators, and the Connecticut State Medical Society, helped the bureau of maternal and child hygiene carry out this request by conducting a statewide survey, with the cooperation of hospitals throughout the State, to obtain information about mothers who had given birth out of wedlock in 2 months of 1950.

The results of this survey, as well as data from other sources, indicated that the medical and social needs of such mothers and babies were not being adequately met. Medical care was often delayed until late in pregnancy or until delivery. Help from a social worker was also often greatly delayed, if received at all. Resources for financial help, especially for medical care, were limited and sometimes not available. Restrictions about the use of funds for helping people in need sometimes defeated their purpose. Some mothers in seeking a means to solve their financial problems made unwise plans for themselves and their babies.

In the spring of 1952, the State department of health, with the approval of the medical society's committee on public health, began a 2-year service and study program in three rural counties—Litchfield, Tolland, and Windham, with a total population of some 200,000—which were estimated to have 60 illegitimate births a year. The project was financed by Federal funds allotted to the State for maternal and child-health services. It was developed and administered by a physician and a medical social consultant on the bureau of maternal and child hygiene staff. Its primary purpose was to help unmarried mothers to obtain coordinated medical and social services from community resources and to provide payment of their medical expenses when needed.

Another purpose of the project was to gather information on the needs of the mothers and their babies, ascertain the strengths and weaknesses of existing services and clarify the responsibilities of the department in a program for unmarried mothers.

A committee of physicians and social workers worked with the bureau to determine the medical and social data to be secured for study purposes.

Referral forms were sent to physicians, social agencies, hospital administrators, and clergymen in the three counties. If the patient at the time of referral was not receiving medical and social services, the project's staff assumed the responsibility of finding medical care and social casework service for her. Medical care was given by physicians in private practice, community hospitals, and maternity homes. Social casework was given by cooperating public and private agencies, principally the Children's Services of Connecticut, the Diocesan Bureau of Social Service, and the division of child welfare of the State department of welfare.

Although counseling services were offered to all patients referred, the study was limited to those who were assisted with the payment of medical care. Study data were obtained through the cooperation of physicians, hospital staff, and social workers.

The Mothers in the Study

During the 2-year study period, 46 expectant mothers were referred to the project: 17 in the first year, and 29 in the second. Physicians referred 19, social agencies 29, and a hospital administrator 1. Three were referred by both a physician and a social worker.

The bureau of maternal and child hygiene made no payment of medical care for 19 of those referred. Two of these 19 did not follow through on their physician's referral because of their fears of a State agency. The 17 others all received some social casework help. Of these, 2 were married before their babies were born; 9 received financial help for medical care from their families or from other resources; 6 had no financial problem and needed help in planning only.

The 27 patients in the study received both financial help for medical care from the bureau of maternal and child hygiene and social casework service from a cooperating agency. All but two were residents of 1 of the 3 counties in the study. The nonresidents were a woman who had moved from another county to conceal her pregnancy and one schoolgirl from Massachusetts who had been sent to her aunt's home when her parents learned of her pregnancy.

Twelve of the patients were in their later teens at the time of delivery; 11 were between 20 and 30 years old; the remaining 4 ranged in age between 31 and 40. This is similar to the age distribution found in other studies. All 27 were white—the population of the three counties being predominantly white.

One woman was a graduate of a teachers' college; another had attended college for 2 years; 5 were high-school graduates; 7 had completed 3 years of high school; 7 had had 1 or 2 years of high school; 3 had gone through the 8th grade only; 3 had not finished elementary school.

One of the mothers who had not finished elementary school had been in a "special class" for children of low intelligence. She herself was an illegitimate child, with a severely deprived childhood. Her baby developed very well and was adopted. The study data lent no support to the common supposition that a large proportion of unmarried mothers are mentally retarded.

The study material included the family background and childhood experiences of these mothers. In most of the homes there were one or more factors not conducive to healthy personality development: only one parent in the home; a rejecting parent or stepparent; a domineering parent; cultural conflicts between parents and children.

At least six patients came from homes where alcoholism of one or both parents was a serious problem. Two others had been removed from their homes during their early childhood because of parental neglect. They had grown up in a succession of institutions, boarding homes, and work homes.

Many of the unmarried mothers had little conviction that they mattered to anyone. Some were resentful and reckless because of never having had strong personal ties. Only eight of those in the study had any depth of feeling for or hope of permanent attachment to the putative fathers of their babies.

Twenty mothers were single; 3 were divorced; 3 were separated from their husbands; 1 was a widow. Four of the single women had previously had a child born out of wedlock. Two of these children were living with their mothers; one had been adopted by relatives; the fourth was living with relatives but had not been adopted. One mother had had 3 legitimate children; one had had 2; 4 others had had one each.

Living and Employment

The mothers' living arrangements changed frequently during the course of pregnancy. Eighteen lived with their parents part of the time. A few lived with other relatives and with friends, and one lived for a while with the putative father. The so-

cial agency arranged for foster-family care for one girl prior to her entrance to a maternity home. Eight others went to maternity homes: one left after a few days and went to her godparents' home. Three of the women who had been married moved from their home communities in order to conceal their pregnancies.

Ten of the patients were working in factories at the time of referral, 6 were in domestic service, 4 were students, 3 were waitresses, 2 were officeworkers, and one was a laundry worker.

Fifteen of the 22 employed women did not give up their jobs until they were in the last trimester of their pregnancy; 4 continued working into the 9th month, and 1, a waitress, worked until the day of her delivery.

Only five of the mothers had any savings at the time their employment terminated. One had saved $200, and the other 4 less than $100. Nine had debts, ranging from small amounts to $800. Only four mothers were entirely self-supporting during their pregnancy. Nineteen received some help from relatives, 4 from other sources—1 from her town, 1 from her church, and 2 from friends. The social workers reported that all had adequate food, shelter, and clothing.

After the baby's birth, all but four of the mothers continued to need assistance for their maintenance. The help came from much the same sources as during pregnancy, with a slight increase in agency participation. In contrast, agencies assumed considerable financial responsibility for the babies. Only one putative father contributed toward a baby's support.

Time of Referral

Sixteen mothers saw a physician before the seventh month of pregnancy, but prenatal care was not always continuous; eight delayed seeking prenatal care until the seventh month or later. The social workers expressed the opinion that these delays stemmed primarily from psychological factors, such as feelings of anxiety and guilt and reluctance to accept the fact of pregnancy. For 3 mothers lack of funds was a factor, and for 2, lack of understanding of the importance of medical care.

Table 1 compares the time of first visit to the physician with the time of referral to the bureau.

The records show that in 11 instances, a lapse of 2 or more months took place between the first visit to the physician and referral to the bureau. The records also show some of the reasons for these delays. In two instances it was not possible for the physician to make an early referral: in one, the mother delivered just as the program opened; in the other, the mother, in her fourth month, consulted a urologist unfamiliar with the program—her only medical contact until her ninth month.

TABLE 1

Month of pregnancy	*Time of first visit of mothers to M. D.*	*Time of referral of mothers to BMCH**
	Number of mothers	Number of mothers
2d	1	0
3d	5	0
4th	4	1
5th	2	2
6th	4	3
	Before 7th month—16 mothers.	Before 7th month—6 mothers.
7th	4	3
8th	1	4
9th	2	11
At delivery	1	0
Postpartum	1	3
	From 7th month to postpartum—9 mothers.	From 7th month to postpartum period—21 mothers.
		0
Unknown	2	

*Bureau of Maternal and Child Hygiene, Connecticut State Department of Health.

One patient waited for 2 months before following her physician's advice to seek the help of a social agency in planning for the baby's placement. Two others were referred early in pregnancy directly to a social agency which explored other resources for payment of medical care before requesting it from the program.

Two patients had early and continuing medical care, but their physicians did not refer them for social-work help until late in their pregnancies; four others had good prenatal medical care but were not referred at all by their physicians. These four in seeking help passed from one person or agency to another before finally reaching the appropriate social agencies.

The physicians tended to see the services of social agencies chiefly in relation to child placement and not as a resource to help the unmarried mother with her own problems. Few of the mothers who planned to keep their babies were referred by their physicians for social help.

One girl, who had sought help through a clergyman and a probation officer, had been referred to a maternity home in Boston, which did not accept her. In desperation she took an overdose of sleeping pills, and was sent to a State mental hospital for observation. She was discharged with the diagnosis of psychoneurosis and the recommendation that she have care in a maternity home. The hospital so-

cial worker referred her to a social agency that could meet her needs. This agency provided the following services: help through casework interviews in working out some of her emotional conflicts; temporary employment as a mother's helper; arrangements for maternity-home care in the final weeks of her pregnancy; referral to the bureau for assistance with medical expenses; placement of her baby for adoption.

Medical Care

Few of the mothers had early and continuing prenatal care. However, except for a high incidence of prematurity, the medical findings were not unusual. Six patients were reported as delivering before term; four of these had premature babies, defined as babies weighing 5½ pounds or less. Two full-term babies were also "prematures" by this definition.

Only 11 patients are known to have had a postpartum examination 6 weeks after delivery. One factor which made the postpartum examination difficult to achieve was the lack of continuity of care by a single physician when the patient was delivered away from her home community. One maternity home, with the cooperation of the clinic used for care of the girls in residence, facilitated the girls' return to the clinic for the postpartum examination. In the other maternity home the mothers were advised to return to the physician in their own community who had examined them prior to their admission. It is not known what steps were taken to help the other mothers to receive a postpartum examination.

Only two mothers were referred for public-health nursing services.

The Babies

Twelve boys and 15 girls were born to these mothers. Three of the 6 premature infants required hospitalization for 17, 21, and 24 days. The smallest, described as sluggish, weighed 4 pounds 5 ounces; and the largest weighed 5 pounds 8 ounces. The full-term baby of the 40-year-old mother required resuscitation and oxygen at birth and later was reported to have a convulsive disorder. Otherwise, the condition of these babies at birth was good.

Reports were received on the health of 23 of the babies up to age 6 months. At that age all 23 were under medical supervision. Twelve had completed a series of immunizing injections against diphtheria, whooping cough, and tetanus; plans for immunizations were under way for two others. One baby had had frequent colds; one, flu; one was a "mild feeding problem"; one had periodic convulsions. One baby had a birthmark, or hemangioma, which might require future treatment. One had developed generalized infantile eczema. The condition of one premature baby suggested the possibility of spasticity. This baby, who had suffered a period of very poor care in a private placement arranged by his mother, was also seriously malnourished.

The Mothers' Plans

Table 2 shows that once the baby is born, the mother is apt to change the plan she had made for him during pregnancy.

At 6 months after birth, 10 babies were with their mothers, 5 were with adoptive parents not related to them, 8 were in boarding homes, 3 were in an institution, and 1 was with a friend of the mother. These arrangements reflect some further changes in the mothers' plans as well as the time sometimes required to work out adoption placements. Social agencies were continuing service to 18 babies.

Subsequently, 6 of the babies in boarding homes and 2 of those in institutions were placed for adoption. All adoption placements were made by social agencies.

Ten mothers eventually decided to keep their babies with them permanently. Some of their reasons are discernible, others remain obscure.

One young woman with deep feelings of guilt and shame went to a social agency to seek adoption for her unborn child. Casework interviews helped her to ease these feelings. After her baby girl was born she developed such strong affection for her that she summoned up the courage to tell her family and won their acceptance of herself and her child.

Two other mothers, who had been wards of the State because of parental neglect, said they wanted to keep their babies to prevent the same fate from happening to them. They seemed to need someone of their own to love. One mother, who had previously had an illegitimate child, took her baby to her parents' home, where he was not welcome. Her insistence on taking her illegitimate babies home seemed to be a retaliation against her dominating mother.

Culture also may have played a role. The small mill towns of eastern Connecticut are populated largely by people of French-Canadian background whose attitude in regard to illegitimacy seems generally more tolerant to the girl who keeps her baby than to the girl who gives her baby up for adoption.

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Why did some mothers decide to give their babies for adoption? Again, it is impossible to determine all the factors that brought about the decision. For two 16-year-olds, immaturity was an important factor, but protection of the reputation of these girls and of their families also entered into the decision. Family position precluded any plan other than adoption with at least 4 other mothers—one a 40-year-old widow with 3 children who was well regarded in her community and highly sensitive to the opinion of others.

Some mothers concerned primarily with their babies' welfare chose adoption as offering their children the most promising future. These were the mothers who seemed to have come through their experience with increased maturity.

There were, however, several mothers choosing adoption who showed little interest in their babies. Their babies seemed to lack reality for them. One girl came from a home from which the father had disappeared and the mother was psychotic. At the age of 10, she had been placed in a children's institution for 2 years. Later she ran away from home several times and at 16 she married a man she had known only a few days. He deserted, leaving her with their child, whom she took to his parents. The putative father of the new baby also abandoned her. She refused to see the baby and took little responsibility in planning for him.

Two other mothers said they wanted to keep their babies but seemed unable to plan for this or to make any sound plans for their own lives. Eventually they gave up their children for adoption.

Several Months Later

By 6 months after the birth of their babies, three mothers had married men who seemed stable and responsible. One of these mothers had kept her baby with her. Later, another mother married a 55-year-old man, who made a good home for her and her two illegitimate children. Two others were engaged to men in good standing in their communities; another also was engaged but the study staff obtained no information about her fiancé. One girl had followed a man to another State and was waiting for him to obtain a divorce and marry her; later they were married but before their child was born he deserted her. Another mother had another child before a year had passed. She had married the father a few months before the child's birth but had been deserted within a few weeks.

TABLE II

Mother's plan	*During pregnancy*	*After birth of a baby*
Keep baby	5	11
Adoption	16	12
Boarding care	3	4
Unknown	3	0

Six mothers were living with their parents and their babies, one receiving aid to dependent children, the others working. One of these mothers took little responsibility for her baby; she was hoping to marry a man (not the putative father) as yet undivorced, whose wife was in a mental hospital. Another was giving good care to her baby along with her legitimate children and her financial situation was good; but she longed to be reconciled to her husband, and failing in this, was uncertain about whether she ought to establish her own home for herself and her children. The four other mothers living with their parents and their babies seemed to be enjoying their babies and to be well adjusted. Another had left an unhappy home and had gone with her baby to another State to live with friends. Still another had gone out of the State with her brother and her baby and was reported to be living in comfortable circumstances.

Nine mothers were living in their parents' homes without their babies. The situation of one was not reported. Six seemed able to take up their responsibilities and to face the future with more confidence in themselves; 1 of these had returned to school and the other 5 were working. Another, not working, seemed happy at home. One mother who was supported by her parents was unhappy because they would not permit her to have her baby with her. She had placed him with a friend. She was the only one of the 9 who had not made an adoption plan.

One mother, embittered by her unhappy experiences with her ex-husband and with the putative father, was leading a lonely and isolated life in her own home with her legitimate son.

Six months after they were born, five of the babies had been placed for adoption under agency supervision. Four of the eight babies in boarding homes were about to be placed in adoptive homes.

The other four babies in boarding homes presented a variety of problems which delayed adoption placement. One was of mixed racial background; later he was placed for adoption with a fine family

of similar racial background. Another could not be placed because her mother clung to the hope of eventually making a home for her; later the mother married a man who refused to accept the child and so she gave her up for adoption. Another of these babies had been committed to the State commissioner of welfare after his indecisive mother had independently placed him in a very poor home; when she eventually gave consent for adoption, his physical condition delayed placement. The adoption plan of another was held up because, although he tested well psychologically, periodic convulsions and hypertonicity of the legs indicated the need for further observation.

Three babies were still in the nursery of a maternity home at the age of 6 months. Foster families had not been found for them because the placement agencies, without sufficient staff to develop a temporary foster-family program, had concentrated their efforts on adoptive home finding. One of these babies had generalized infantile eczema, which had been a factor in the delay in placement for adoption. Another was the child of a mother who could not bring herself to make a permanent plan. This mother's stepfather would not let her take the baby home, but she wanted the child, contributed to her support, and visited her in the institution. The social worker believed that the girl clung to the child as a means of contact with the putative father and to satisfy her own needs for affection. As the oldest of a large family of stepbrothers and sisters, she had felt that her mother had never had any time to devote to her and that her stepfather had never accepted her.

The situations of the babies who were with their mothers at the age of 6 months seemed good in five cases and questionable in the other five because of unresolved economic and emotional problems in the homes. In most of these instances it could be expected that the child would face the difficult problem of conflicting relationship with two mother figures, his mother and his grandmother. None of the babies seemed physically neglected.

Evaluation of the Program

How effective was the financial assistance of the program in coordinating medical and social care and what influence did it have on the welfare of these mothers and their babies?

These questions are hard to answer, but an attempt to do so was made in the social workers' reports on each mother and her baby.

Did help with medical expenses result in the mother's receiving medical care or social help sooner than she would have?

The social workers' replies to this question revealed that three mothers received medical care sooner because of the program. These mothers went late in pregnancy to a social agency and the bureau's financial assistance expedited arrangements for their immediate medical care. Otherwise they would not have seen a physician until delivery.

Seven mothers received social help earlier because of the program. Four were referred to the bureau for social and financial help by physicians, and one by a hospital administrator. Two others, referred by social agencies, had come to the agencies seeking help only for medical expenses. When relieved of their financial worries they were able to use the agencies' casework services.

Did payment for medical care influence the mother's plan for herself and her baby?

The answer was decidedly yes. Because of this payment, some mothers could use their limited resources to live outside their own communities during their pregnancies and to pay for temporary foster care for their babies. One unwise marriage and one unprotected adoption might have occurred if the mothers concerned had not had this help. Relief from the financial worry enabled several mothers to come to their decision on adoption more thoughtfully. About half the mothers who kept their babies felt freer to do so because they were not burdened with medical debts.

Although the social agencies giving service were handicapped by staff shortages and late referrals, the social workers reported that their service to 22 of these mothers was facilitated by the program. They also expressed general approval of the program's procedures. No personal application to the bureau was required but only the mother's consent. Eligibility was determined on the basis of information supplied by the patient's physician and social worker.

What shortcomings in services do the case records reveal?

1. Prenatal care was often inadequate. Even when they consulted a physician early in pregnancy, few of the mothers remained under care.

2. Postpartum examinations were seldom done.

In some cases this was because of a change in physicians, in others because the physicians apparently did not stress their importance.

3. Public-health-nursing services were rarely used.

Neither physicians nor social workers seemed to have a good understanding of the ways in which a public-health nurse might help.

4. Referral for social care was often delayed.

Physicians and others to whom the mother turned for help often lacked either knowledge of resources or understanding of the ways in which social casework could be of help. After it had been initiated, social workers sometimes failed to keep in touch with the doctor during the time when they were both trying to help the mother. Some social workers who tried to communicate with physicians became discouraged because the latter were too pressed for time.

5. The problem of financing predelivery residential care for the mother and board for the baby during his early weeks was not resolved. Some mothers had to go into debt for the residential care or were forced to remain in their home communities. In Connecticut if an unmarried mother is unable to support her baby prior to adoption placement, and if a social agency cannot finance his care, he may be committed to the State department of welfare through the juvenile court, which must charge the mother with neglect.

The program pointed up other problems that call for further study. They require finding ways of: (1) reaching the mother early in her pregnancy; (2) achieving closer working relationships among physicians, nurses, and social workers; (3) stimulating fuller community support of resources.

Current Efforts

Despite the problems mentioned above, the department and the cooperating physicians and social workers believe that the program has made a positive contribution to the health and welfare of unmarried mothers and their babies. The Committee on Public Health of the Connecticut State Medical Society has recommended extension of the program to additional areas. The social agencies have also asked that it be expanded and have pointed to an important by-product of the experience—a better understanding of each other's functions and policies among the health and welfare agencies involved.

Since the completion of the study the department has continued to carry out the service aspects of the program and has made a number of specific moves to strengthen its weak spots.

In an effort to achieve earlier casefinding, the bureau's staff has had frequent discussions with members of the medical profession, directors of local health departments, administrators of councils of social agencies, policewomen, and others. Physicians of the three counties have been recircularized to remind them of the program and the referral form has been revised to make it easier for them to refer a patient directly to a social agency. The report of the study has been widely distributed among physicians and social workers.

The need for more regularity in medical attention, shown in the study, has prompted the State medical society's committee on public health to focus discussion on ways of assuring this for the girl who comes to the physician early in pregnancy. The bureau has initiated a procedure for followup when the record does not state that a postpartum medical examination has been made.

The bureau has also added a public-health-nursing consultant to the project's staff to help physicians and social workers to see the role of public-health nursing in meeting the mother's needs for health guidance, and an understanding of what to expect during pregnancy, labor, and delivery. All the members of the project's staff have been working, on a case-by-case basis, with nurses, social workers, and doctors to foster closer interprofessional relationships, and hence, greater continuity of both medical and social care.

The department has developed a plan for extending the service aspects of the program to a fourth county and its consultation services to the entire State. While the original three counties are predominantly rural in area, the new county contains a large city which has more social and health facilities available. The plan also envisages the formation of local advisory committees in all counties and a much more widely representative general advisory committee with functional subcommittees to create a broader understanding of the problems of unmarried motherhood, to promote early casefinding and better care, and to make studies which will be useful to program development.

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[1] Connecticut State Medical Journal, May 1949. (p. 487)

COMMUNITY CLINICS FOR THE MENTALLY RETARDED

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IN THE LATTER PART of 1949 a group of parents in New York began to explore the possibility of establishing some special clinical facilities for themselves and their retarded children. Most of the parents in this group had done a good deal of "shopping" for help. It seemed to them that the existing clinics could not and did not answer their need. These facilities were too limited and too overtaxed with other problems. Their intake policies were too restrictive. Most of them lacked staff experienced in dealing with the mentally retarded. In most of them treatment was not available to the "less responsive" mentally retarded patients.

The few special clinics which were in existence for the mentally retarded at that time were largely limited to sorting and labeling the mentally retarded—to separating them from the normal and from other handicapped persons. They were used in certification and commitment procedures, in determining eligibility for special classes and in some research programs. Their function was a limited diagnostic one.

The parents in New York wanted special clinical facilities which had a much broader purpose. They wanted more than a labeling-and-sorting operation. They wanted some definite answers and some continuing help. As parents they wanted to know what was wrong with their children: Why had this tragedy happened to them? What had caused it? What could be done about it? They wanted the kind of help for themselves and their retarded children that they could get from a child-guidance clinic or medical clinic if their child had a behavior problem or an orthopedic condition—evaluation, diagnosis, interpretation of findings, and continuing guidance and management supervision.

In 1949, these parents were unable to find anywhere in the United States an example of the kind of clinic they had in mind. There was little guidance professionals could offer. No one had experience in providing the type of service they wanted. No one quite knew what it took or how best to design such a service. What the parents finally set up was an exploratory demonstration project, based on some judgments, a few guesses, and lots of hope.

Five years later, in 1955, the member units of the National Association for Retarded Children, in a survey of their activities, reported that 33 such special clinics for the retarded were either being operated directly by them or had been stimulated by them. According to this survey, 12 additional clinics were being planned for 1956.

The growth and expansion of such clinical facilities within the past year has been even more rapid. Many more have been developed by parent groups, hospitals, and private foundations. In addition, through congressional appropriations the Children's Bureau has assisted health departments in 21 States and Territories to establish special projects in mental retardation, all of which include some aspects of special clinical services to young mentally retarded children and their families.

While the definition of clinic varies, about 75 community clinical programs for the retarded in various parts of the country could be listed at the present time. In view of their increasingly significant place in the total program for mentally retarded, it is important to examine them critically. How have they

been developed? What administrative and functional pattern have they evolved? Where have they failed? What have they proved? Which of them could serve as models for future developments?

While the enthusiasm of the parents' groups which stimulated these clinical programs created an extremely favorable atmosphere for experimentation and the evolution of new patterns of service, it also developed a negative aspect—a feeling of distrust of anything that already existed. What was known and what had been done had not met the need. None of it could be used. At times this feeling resulted in the discarding of basic principles of services to people and in losing track of basic human needs which the mentally retarded have in common with other individuals. Mental retardation was viewed as a specific subnormal condition of the intellect and the approach was to this subnormal condition alone.

Clinic Patterns

The effect of many of these positive and negative factors on the new special clinics is evident in their operation, functioning, and achieved results. Some of the problems created by the lack of clarity as to how mental retardation should be defined are also reflected in the operations. Some of these clinics have been unable to say who is to be included in the category of the mentally retarded as far as their own operations go. Some are still struggling with such questions as to whether mental retardation is primarily a social problem or whether it is a medical, a psychological, an educational or a psychiatric problem.

Naturally, the way a clinic answers these questions has a bearing on what it does and how. The answers will determine, for example, whether there is medical direction, whether there is a team approach, whether the child or the parents are the focus of attention in the helping process, what is included in evaluation, and what kind of help is offered.

The new special clinics which have sprung up since 1949 are variously organized. They include facilities patterned after the traditional pediatric outpatient service; the traditional child-guidance clinic; single-discipline guidance centers staffed only by psychologists or social workers; and various combinations of these patterns. They include facilities directed by pediatricians, psychiatrists, psychologists, social workers, nurses, educators, or others, with different program emphases resulting from different professional direction. Goals and purposes are variously defined. Indeed, in looking at this assortment of new clinics, one is at times struck by the fact that the only thing which many of them have in common is the kind of patients they serve—the mentally retarded. But even this diagnostic category is defined differently in different clinics.

Despite the varying concepts as to what a special clinic for the mentally retarded should be, much has been achieved through these experimental demonstrations.

New resources have been brought to bear on the problem. For example, the special projects of the Children's Bureau, developed by the maternal and child-health programs of the State health departments, have produced a public-health approach in the provision of clinical services to younger children. Directed by pediatricians, they provide clinical teams, usually consisting of social workers, psychologists, public-health nurses, child-development specialists, and consultant psychiatrists.

Experimentation in the clinics which have existed for several years has proved and disproved a great many assumptions and concepts about mentally retarded children. For instance, observations of mongoloid children living at home have demonstrated that these children do not necessarily follow the stereotyped behavior pattern, so frequently seen in institutions, of being sweet and docile.

These clinics have emphasized the individuality of the person who may be retarded. They have demonstrated the need of retarded persons for primary services in health, education, and welfare as well as for special help.

The achievements of some of the older clinics have not always been clear to the parents who have turned to them. From the point of view of these consumers there have been many shortcomings in services. Limitations of funds and staff, long waiting lists, and too little followup after evaluation have been responsible for some dissatisfaction. Financial and staff shortages prevent most of these clinics from dealing with all of the aspects of each problem presented. In some clinics certain aspects of evaluation and treatment are emphasized, depending upon the setting and the interest and orientation of the director. This emphasis may not fit in with the needs of each parent or child coming to the clinic.

A 2-year-old severely retarded child and his parents have different needs from a 12-year-old educable retarded youngster and his parents. They require different types of skills and services in different degrees of concentration, with individual variations, of course. Mapping out a program of

daily care for a severely retarded 2-year old is not a psychiatrist's area of greatest competence. On the other hand, most pediatricians would not consider themselves equipped to deal adequately with a severe behavior problem presented by a 12-year-old retarded, but otherwise healthy, boy. The parents of the 2-year-old might require the assistance of a public-health nurse, a medical social worker, and some nutritional, occupational, and physical-therapy consultation; whereas the 12-year-old youngster and his parents might need a good deal of psychiatric help from a psychiatric-clinic staff, including guidance from a psychiatric social worker and from a psychologist.

Differences Within the Category

To serve mentally retarded children and their families well, planning for community wide services takes into account the individual differences within families, the various causes and degrees of severity of retardation, the different ages of the retarded children, and the different behavioral expressions.

These differences call for a variety of clinical services, all of which have a place in an overall, balanced program for the mentally retarded. No one clinic can be designed to meet their total needs, any more than one clinic can take care of all the needs of normal people. We do not expect child-guidance clinics to provide well-baby care. We do not expect geriatric services to care for children.

Approaching the question of special clinical facilities in this manner, the kind of direction, approach, and staffing pattern utilized really would depend upon the kinds of problems, the functioning levels, chronological ages, and developmental stages with which the clinic was attempting to deal. As do normal children and adults, mentally retarded individuals go through certain developmental stages. Within each developmental stage certain needs are paramount. Clinics must be staffed and have their programs planned to meet the needs characteristic of each stage.

Taking these stages chronologically we come first to the prenatal period.

It has been estimated that approximately 90 percent of the known conditions[1] resulting in mental retardation originate in the prenatal period. If this proves correct, special attention must be given to all known possibilities of prevention.

While a great deal of research still remains to be done, we do have some knowledge about the relationship of prenatal life to mental retardation. For example, we have some evidence of the adverse effect on the fetus of nutritional deficiencies and we know of certain complications of pregnancy, such as German measles occurring during the first trimester, or the Rh factor.

Preventive efforts depend upon the development of criteria for detection of conditions during pregnancy which might result in mental retardation and the better application of already existing knowledge of day to day prenatal and obstetrical care. These efforts should focus on alerting medical and other personnel, through refresher courses and other means, to recognize clinical signs of conditions in an expectant mother which could result in mental retardation in her unborn child. Such efforts would include making available to the medical practitioners consultation services from a variety of specialists and providing laboratory facilities to assist in the evaluation of suspect cases and in outlining specific treatment approaches. To be effective such consultation requires coordinated effort and a team approach.

Following delivery, the care and treatment of the newborn infant who is mentally defective requires experts with other skills. From the prevalence studies which have been completed, we might expect to identify approximately 2 mentally retarded children per 1,000 infants under a year old. Retardation to be detectable at this age has to be severe. Undoubtedly better casefinding methods will increase this rate. Also, as diagnostic techniques are improved, some less severely affected children might be recognized as mentally retarded at this age. Nevertheless, the known group would be made up largely of infants diagnosed at birth as being mentally defective.

Care of Infants

Diagnosis of mental impairment in infancy is based largely on the existence of one or more of a variety of congenital abnormalities generally associated with mental retardation. Such diagnosis rests with the physician, as does the primary responsibility for interpreting the child's condition to the parents. Since what has been diagnosed is a specific medical condition or a symptom picture, which it is assumed will result in mental retardation, the initial assistance provided to parents in meeting this impact should primarily come from the physician. Likewise, any treatment which might stop or reverse the progress of these congenital conditions must derive from medical prescriptions.

Pediatric services are of first importance for main-

taining the health of mentally retarded children, just as they are for the health of all children. Many of the infants in this group have a weak hold on life. Without skillful prenatal and obstetrical care many of them would not survive.

A program designed for newborn infants identified as being mentally retarded requires therefore pediatric direction. Its clinical services must be directed toward:

1. Prevention of further organic damage, particularly in such conditions as galactosemia and phenylketonuria.

2. Health supervision for the infant.

3. Interpreting the child's condition to the family, planning with them for the child's care, and helping them get the help they need.

Since most retarded infants are under the care of private physicians, consultation services to assist physicians in carrying out these functions should be part of the total planning.

The One to Fives

In the age range of 1 to 5 years the number of children identified as mentally retarded increases. Diagnostic instruments in this group become a little more sensitive so that some less severely retarded children can now be recognized. The prevalence rates in studies [2] suggest that we might expect a rate of 4 mentally retarded children per 1,000 in the 1- to 2-year-old group; and of 6 children per 1,000 in the 3- to 4-year-old group.

Differential medical diagnosis is more complicated in this age grouping. Children who fail to perform like their peers in the expected sequence of development are frequently suspected of being mentally retarded. Visual and hearing difficulties, cerebral palsy, and other physical handicaps frequently interfere with functioning, and the resulting lag in development becomes apparent. Determining whether developmental lages are due to sensory defects, other disorders of physical and psychological nature, or mental retardation is an important aspect of service for children from 1 to 5.

The differential diagnosis, arrived at by the physician with such supplementary findings as he seeks, now requires a continuing contribution from the psychologist for a stage-by-stage evaluation of the rate, deviations, and strengths of the developmental process.

The reactions of parents who learn about their child's retardation during these years are different from those of parents told about their child's defect shortly after delivery. The parents of an older child who had assumed that he was normal, may slowly accumulate evidence that something is wrong, such as little or no learning from experience, or apparent incapacity to move from crawling to walking. These are the parents who are apt to shop around, driven perhaps by a mixture of disbelief and hope. The sooner they obtain definitive diagnosis and evaluation, the sooner they can turn their energies to productive activities on behalf of their child. They then are interested in some specific advice and guidance in such matters as training the child to crawl, sit, walk, talk, feed himself, dress, undress, go to the toilet, and perform other aspects of self-care. To provide parents with this kind of help a home training program becomes an essential element in the services of a specialized clinic.

Clinic services for retarded children of preschool age must be geared to serve the moderately retarded whose retardation may not be discovered until they are as old as 4 or 5. On the whole, these children will function at higher levels than those whose retardation was apparent earlier, and they will have had several years of comparatively "normal" relationships and experience in family life. Their retardation may show itself in slight deviations in specific areas of development, such as speech or play patterns. These children may be ready for their first supervised group experiences, which they might receive in play groups promoted by the clinic, by some other agency, or by a parents' group. Having had preliminary satisfying experiences with other children, a fair proportion of them are capable of participating in regular nursery programs. For example, a 5-year-old who looks and acts like a 4-year-old might be placed in a regular 4-year-old group.

The total group of children known to be mentally retarded swells in number during the first years of school attendance because it now includes those who have been identified as retarded because of their inability to cope with school demands. Severely retarded children come to represent only a small minority of the total group.

Behavior and emotional difficulties are both more prevalent and more prominent, bringing a greater need for psychiatric help. Community planning for this group centers primarily on providing educational facilities, and necessitates the gearing of clinical services largely to determining a child's readiness for school and providing diagnostic information

to the schools to help them map out appropriate educational programs. The clinic would have to be staffed by personnel able to treat effectively the behavior problems of retarded children and to differentiate diagnostically between the children who are mentally retarded and those who are emotionally disturbed. Parents who first learn of their children's retardation during early school years face a different situation from that of parents who learned during their child's infancy or early childhood of their children's condition. Many parents of a school-age retarded child presumed, before he entered school, that their child was normal and enjoyed a few years of relationships with him unclouded by worry about his abilities. To readjust their concept of their child and still maintain a healthy relationship to him, as they vacillate between belief and disbelief following the school's detection of the mental retardation, often requires casework help spread over a long period.

Adolescents and Young Adults

In adolescence and early adult life, severely retarded persons continue to require special and separate facilities. So do those who are capable of functioning more fully but in whom mental retardation has become complicated by emotional deprivation and lack of training. However, most of the mildly retarded individuals who were defined as "educable" during their school years apparently no longer require special community services. They have become at least marginally self-sufficient and have apparently found a place in the community as earners.

With young adults the need to work and produce is a major drive. Those young adults whose mental retardation is of such a nature as to require continued community programming profit from vocational education, employment guidance, and job placement. Some require sheltered work opportunities. Social and recreational programs, which may have to be developed especially for such individuals, must also be an important element of planning. Psychiatric help should be available, of course, because of the inevitable strains on the mentally retarded even in the most protected situations.

Problems of sex, dating, and marriage present themselves in adolescence and adulthood. Many retarded persons are unable to cope adequately with these drives. Individual problems approximate a chronic pattern of withdrawal, regression, dependence, and isolation. There is preoccupation on the part of both the retarded adult and his family as to what will happen when the family no longer is able to provide supervision.

In general, clinical services for adult retardates also have a special contribution to make in evaluation of work potentials, supervision of health problems related to the retardation, and the reevaluative observation which would spot possible deteriorative processes. Among some retardates there is the breakdown of some physical functions and the emergence of some senile patterns at an earlier chronological age than is usual.

In addition to the kind of evaluation just described, clinical services for adult retardates must be prepared to offer supportive guidance and casework help.

The development of clinical services for people who are mentally retarded, therefore, is not a simple undertaking. Such services cannot be provided in the same way as services for specific organic disorders. The category of mental retardation is too broad and nonspecific. It includes too wide a range of human needs to make it practicable to attempt to meet all of them in any one clinic or with a set pattern of clinical specialists. Services people require at differing developmental stages should determine the staffing patterns at such stages.

The sequence in establishing the various units of clinical services to achieve a totally balanced program should be guided by community leadership decision on what degrees of retardation and what age groups require attention first.

[1] Yannet, Herman: Classification and etiological factors in mental retardation. Journal of Pediatrics, February 1957.

[2] New York State Department of Mental Hygiene: A special census of suspected referred mental retardation, 1955.

". . . the education of the young child takes place through the quality of his living rather than through words we say, techniques we use or the deeds we demand of him.

James L. Hymes, Jr., at the eighth annual conference of the Southern Association on Children Under Six, Berea, Ky.

INDEPENDENCE AND IDENTITY IN ADOLESCENCE

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THE FIELD of adolescent psychology has long been dominated by a biological-developmental viewpoint. The finding of social anthropologists that many vicissitudes of adolescence are not caused by biological changes but are wedded to puberty by cultural circumstances has brought modifications in the developmental approach, but has not decreased its ascendancy in the field.

It was natural for pioneer researchers to view adolescence through a developmental framework, since puberty is marked by dramatic biological growth and the emergence of full sexual capabilities. But this framework, like any, limits as well as defines the area of investigation. The developmental approach—with its age-graded tables and careful efforts to measure norms of growth—has obscured or caused neglect of some facets of adolescent psychology, including sex differences.

In two recent studies the Survey Research Center at the University of Michigan has gathered extensive data on adolescent boys and girls. One of the first results of these surveys has been a reassessment of the importance of sex differences in adolescence—not only in the solutions of developmental tasks but in the very nature of the tasks that are posed for boys and girls in our culture. Specifically, our findings have led us to speculate that the issues of independence and identity—though crucial in the psychology of the adolescent boy—are not so clearly stated for the girl in adolescence and may not be posed for her at all until a later period in life.

The data come from two national sample interview studies of adolescents. The first had a sample of 1,045 boys 14 to 16 years old in school; the second used a sample of 1,925 girls in the 6th through 12th grades of school (ages 10 through 18). In both studies the samples were drawn by modified random methods, to insure representation of the total population of children in the United States in the desired age range and attending school at the time.[1]

Each boy and girl was interviewed at school by a trained interviewer. The schedule consisted primarily of open-ended and projective questions. The children were encouraged to give full and free responses, which the interviewer recorded verbatim. Interviews took from 1 to 4 hours.

In the course of interviews, boys and girls of the same age revealed many similar concerns and problems, as well as many that were sharply different for the two sexes. This article will concern itself only with those findings which dealt with independence from the family and the processes of identity formation.

The term "independence" may denote a number of separable issues in the life of an adolescent. It may refer to economic independence or to the fact that the child is permitted considerable freedom to come and go and to regulate minor affairs of his life on his own. When, however, we speak of independence as the central issue of adolescence we usually mean to indicate the process by which the child casts off infantile ties of dependence and arrives at a more mutual and adult relationship with his parents. A major part of the process is the sloughing off of external authority and a substitution of more internal and mature standards and controls. This is the aspect of independence to be discussed here.

When we speak of the adolescent's developing independence we often think of terms like resistance, rebellion, rejection of parental standards. We com-

pare the child at this age to the "negative 2-year-old." Aware of his ability to control his own behavior, the adolescent overprotests. Once he sees that he can have a viewpoint of his own, he must for a while reject his parents' simply because it *is* the parents'. Unsure of his independence, he must continuously reassert it, even though he might prefer the parents' way if someone else were to suggest it. His rule seems to be: "Say *no* first, and then decide what you want."

The rebellious pattern bespeaks a real struggle with problems of impulses, control and regulation, and authority. The young person, not yet fully emerged from childhood dependency, is deeply engaged in forming a standard and technique for regulating his own behavior. As he works on this important construction—still unable to tame his own impulses—he must let the world know that, at any rate, *he* must do it. He will not acquiesce to control from sources he now recognizes as external, and so he rebels.

Difficult as this rebellion may be, it signifies an important process of growth in the young person's capacity for self-direction and internal control.

Our interviews with boys and girls reveal that the adolescent boy is characteristically deep in the process of replacing parent-given standards with a new set he is constructing by rough and often painful steps. On the other hand, the adolescent girl, though gaining autonomy in some areas—such as spending money and choosing clothes—is apparently not so burdened by struggle for personal controls. Rather than proceeding to construct her own standards and to reject those of her parents, she seems to accept the standards of her parents and to accommodate them to her more grown-up self. While with boys the process consists of thrust, counterthrust, and construction, for girls it is much more commonly one of assimilation and minor alteration.

Rebellion is not the only means by which an individual may give up deference to external authority and develop his own standards. A more internal and quiet method may accomplish the same end. In looking at the survey data, we have considered signs of internal concern over standards, as well as those of rebellion against externals, as marks of growing independence. Whichever path a young person takes, recognition of the distinction between his and his parents' rules is a necessary condition for developing independence.

Attitudes Toward Rules

Boys are more likely than girls to regard parental rules as an external control on irrepressible impulses. For instance, when asked why parents make rules, boys more often say that the purpose is to keep children out of trouble. Girls more often talk about rules in other terms: parents make rules to teach their children how to behave; to give them standards to live by; to help them to know what's expected of them. Generally, it seems, boys think of rules as a means of restricting negative behavior, while girls consider them a means of directing and channeling energy.

This difference becomes clear again in answers to the question: "What would happen if parents *didn't* make rules?"

Boys emphasize *trouble*: "the children would run wild"; "get in with the wrong crowd"; "wouldn't go to school." A third of all boys interviewed mentioned the last possibility, compared to 2 percent of the girls in the same age group.

Girls agree that the situation would not be good without parental rules. But they more often refer to the effect on society or on the children's health and welfare. They talk about what an unregulated life would do to children: "they'd be spoiled, insecure"; "their health would suffer." Boys refer to what boys would do—one can fairly feel the wish behind the word. More girls than boys say that if parents did not make rules, children might be able to manage their own lives.

We asked all of the children whether they had ever broken a rule. Boys often reacted to this as a rather foolish question. Of course they had broken rules—or, as one lad put it to the interviewer, "You kiddin', lady?" Girls frequently sounded a note of disarming purity and acquiescence. More of them said they had never broken rules, or that they had

The studies on which this article is based were sponsored by the Boy Scout and Girl Scout organizations. They are part of a series of studies of youth and youth programs being undertaken by the Communication and Influence Program of the Survey Research Center, under the direction of Stephen B. Withey. The author's coworkers on these studies were Joseph Adelson and Carol Kaye.

once broken one, or that they supposed they had at some time.

One of the most impressive indications of the difference between boys and girls in their attitude toward authority comes from a series of projective picture-story questions. These consisted of a picture of a boy, or girl, telling his parents he was going out with friends, a second picture in which the parents set a restriction on the adolescent's behavior, and a third in which the boy, or girl, is shown with friends who are suggesting an activity directly counter to the parents' rule. Respondents were to supply answers for the parents, the boy or girl to the parents, and the boy or girl to his or her friends.

Modes of Expression

Responses to the second picture of this series, giving what the adolescent would say to the restricting parents, show a striking difference between boys and girls.

The two groups give about equal proportions of autonomous answers, but their styles of expressing autonomy are very different. A quarter of the boys question the parental restriction—not with hostility or any sign of real conflict, but with a freedom that implies a right to question, while only 4 percent of the girls in the same age group react in this manner. On the other hand, a third of the girls reassure the parents with phrases like "Don't worry," or "You know I'll act like a lady," but boys almost never answer in this way.

Both of these response types reveal a respect for one's own opinions. They both indicate autonomy, but very different attitudes toward parental rules: the boy opposes; the girl not only acquiesces to, but reinforces the regulation.

Girls are also more authority-reliant than boys in their attitude toward adults other than their parents. So, for example, they more often say that an adult club leader should be a decision maker.

Several indications of an external view of authority are more frequently found among boys. When we ask when a boy or girl might break a rule, answers were generally of two kinds: those indicating that the rule is basically accepted, but broken because of some emergency or other external pressure; and those implying a lack of acceptance of rule. The most extreme example of the latter type of response is the answer: "When he thinks he won't get caught." Such an answer indicates that the rule has not been internalized as part of the youth's own set of standards, but is regarded as an external, parentally imposed obstacle to be circumvented whenever possible.

A similarly extreme response came in answer to the question: "What rule would you never break?" This is the answer indicating that the young person cannot think of *any* rule that he would not break.

Picture-story questions stimulated another extreme response. A small proportion of youngsters resolve the dilemma presented—being trapped between a promise to parents and pressure from peers—by adhering to the parental stricture, not because they felt bound by their promise but solely because they fear external punishment.

All three of these responses are extreme both in the highly external view of authority they imply and in their infrequency. However, what is verbalized by a few may be only a more extreme form of something felt by many. Moreover, each of these answers shows a significant sex difference. While the answers are almost never given by girls between 14 and 16 years of age, approximately 10 percent of the boys interviewed gave each of them.

Boys, it seems, are more likely to view parental rules as external and to take a rebellious attitude toward them. In addition, they seem to be more consciously concerned about controls than are girls. In answers to two questions to detect self-awareness, boys show greater concern with establishing satisfactory standards and personal controls. One of these questions was: "What would you like to change about yourself, if you could—about your looks or your life or personality?" A higher proportion of boys than girls gave *internal* responses to this question. Boys more frequently say they would like to have better control of their tempers, be more responsible, be nicer to people, and particularly to their families. When asked what worries them, again more boys than girls refer to internal concerns.

Why the Difference?

Why should girls be less concerned than boys with controls and standards? Why are they apparently less actively engaged in establishing independence from parental regulation? There are probably a number of reasons.

Traditionally girls are more closely protected by their parents than are boys. Society, including the society of adolescent girls, grants this protective power to parents in recognition of girls' greater need for buffers against the expression of newly awakened sexual impulses. In this area, the consequences of acting out are much greater for girls than for boys.

Two teen-age girls scan the questions they will discuss with interviewers of the Survey Research Center. Observing them are Dr. Stephen B. Withey and the author.

Girls recognize the legitimacy of parental regulation in this area when they tell us what parental rules they would never break. A fifth of them refer directly to rules about boy-girl relationships, while none of the boys do. In discussing dating, many girls say that it is all right for a girl to date as long as her parents know and approve of the boy.

Although girls may resent such protection as they enter late adolescence, they continue to acquiesce. Advisers in college dormitories hear girls complain about restrictive hours, but they also know the candid girl who admits her reliance on this external control: "If it weren't for hours, I'd never get any work done. I can't turn down dates, and I wouldn't want to be a wet blanket and insist on getting in early."

On the other hand, no one today would advocate restricted hours for college boys. Any attempt to control boys in this way would probably meet with abysmal failure.

Another reason adolescent girls do not show the same decisiveness as boys in moving toward an independent set of standards may be that the question of identity is postponed for them.

Establishing an identity means finding an answer to the question, *Who am I?* and also consolidating a sense of the internal, continuous self in contrast to all that is external and changing. The issues involved in identity formation weigh very differently for the two sexes. For a man the question *Who am I?* means mainly "What is my occupation, my function, my specialty?" For women identity is expressed in other terms: "I am the wife of John Smith, the mother of three children and, perhaps, the most active gardener in the neighborhood." In other words, identity formation for the girl is more closely tied to her sexual adjustment and her realization of feminine goals.

There is a crucial difference between these two identity challenges: a young person can prepare for an occupational role much more concretely than for marital adjustment. While a boy may begin to aim his thoughts and plans toward his identity goal during adolescence, a girl is in a sense blocked from such purposeful preparation. She may emulate adult women in external and symbolic ways—like wearing high heels—and she may learn housewifely skills. But she is not able to apprentice in the crucial area of maintaining a continuing and intimate relationship with a man with whom she will have children.

One other critical difference in the central-identity issue of boys and girls is in the locus of choice. The boy may choose his own occupation; the girl's "choice" of marriage partner is not an individual decision. She must also be chosen.

How do these differences manifest themselves in our interviews? In general, we find that girls are less absorbed with internal psychological aspects of self-definition and less concrete in plans for the future.

We have noted that boys are more concerned with internal controls than girls. In answer to the questions revealing self-concept, boys give more internal responses of all kinds than girls. They worry more about personal achievement now and in the future, and they wish for more ability. Girls stress external aspects of the self: They wish for physical attractiveness; they worry about clothes and appearance. More girls than boys emphasize acceptance and popularity as goals. While the boy is actively looking for answers to the questions, *Who am I?* and *What will I be?* the girl seems to wonder *How do I look?* and *How do others see me?*

Job Choices

In their talk of the future, boys are very much concerned with occupational plans and decisions. The large majority mention definite occupational goals and have quite clear ideas about how to prepare for them. Their goals imply extended time perspectives and commitment to career lines. These goals obviously may change many times before adulthood, but at any rate the boys are engaged in the process of exploring and choosing identities. They

think about jobs in concrete terms; they make their choices on the basis of interest in the work and an estimate of their own skills and abilities; they are deeply concerned with individual achievement.

What about girls of the same age? We know from direct questioning that nearly all girls hope to marry. Yet when they are asked what decisions they will make in the future and what they look forward to, surprisingly few girls mention marriage. Generally they focus on the years and activities before marriage.

Most girls talk about education and jobs when they discuss their future lives; yet these plans obviously do not strike the central chord of identity in girls that they do in boys. Many girls hope to go to college, but for most of them this seems to be a social aspiration rather than a definite part of job preparation. Girls refer to particular courses of study or professional training much less frequently than boys.

The job choices of girls differed in a number of important respects from those of boys. They do not imply the same career commitment. Only about 1 girl in 10 chooses a future occupation that implies extensive commitment. Most girls want jobs that require only moderate or slight training and that can be held intermittently without serious loss of skill.

The content and interest of the job seems less important to girls than boys. Girls are interested in the kind of job that will provide a congenial social setting within which they make friends and supplant the social life they had in school.

Our interviews reveal one other difference between occupational plans of boys and girls: while boys' vocational choices seem to be at least partly determined by a realistic assessment of capabilities and interests, girls' choices appear to be dominated by popular job images. Girls' choices cluster in a few highly visible occupations—secretary, nurse, teacher—but the boys' choices do not. This may reflect the limitations of vocational opportunities for women, but it may also denote less realism in measuring the job against personal talents.

More girls than boys choose "glamour" jobs; fewer choose manual occupations, although a large proportion of the jobs actually held by women include manual work. In general, the girls' vocational plans seem less realistic than the boys'.

Girls Must Wait

In brief, girls do not talk much of their marriage roles, and are vague and uncommitted about the jobs they discuss so much. What does this mean? We feel that this pattern might be called a defense against the crucial issue. Nearly all of our girl respondents want to get married. But, apparently, the possibility of taking steps toward adjustment to the marriage role is so remote that they focus on the more immediate occupational role.

While both boys and girls must wait beyond adolescence for fulfillment and final settlement of the identity issue, boys at least may orient themselves clearly toward a particular resolution and may begin to acquire skill and experience that will facilitate their eventual identity settlement. Girls, on the other hand, can do little about the central aspect of feminine identity before marriage.

If it is true, as we have speculated, that the identity issue is postponed for the girl until marriage, it may also be true that marriage is the event that precipitates her independence from the family. As she establishes her own family, a girl may find many areas in which she must make her own decisions, and in some cases, decisions that differ radically from those her mother has made. At this point, then, the girl may find herself needing to take the decisive steps toward independent standards that the boy apparently takes earlier in adolescence. In the meantime the girl absorbs what she can from her mother, or other feminine models, about adjustment to the role of wife and mother. And she apparently abides by and absorbs her parents' standards of behavior.

Throughout this discussion, I have referred to our "speculation" about sex variation and independence in identity development. We have only preliminary findings and cannot yet draw firm conclusions from our studies. But these early findings are impressive, and will sensitize us to sex differences as we continue the analysis of interviews with boys and girls.

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[1] Bergsten, Jane W.: A sample of girls from school lists (to be published in the Journal of Experimental Education, March 1958).

WHAT CAN PARENTS DO?

ALINE B. AUERBACH

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A GROUP of 10 parents whose children attended a "preschool child-guidance-center school" joined together in a Cooperative Parents' Group Workshop, led by the school's director, "to find a way of life which has meaning and purpose" and "to understand, to clarify, and become able to see, to give to each child his true inheritance of life." The result of their combined thinking has appeared in a recent little book, "The Challenge of Children,"[1] in which they try to pass on to other parents what they have struggled hard to achieve for themselves. This volume is both challenging and puzzling, for it contains much that is valuable and stimulating, and much also that, to this reader, is dogmatic and misleading. Because of this double effect, it is important far beyond the merits of the book itself. Both its assets and its limitations represent trends to be found elsewhere in parent education today, although they are seldom so closely woven together in one volume.

This is an exhorting book that obviously has grown out of an intense and meaningful experience. The goal of its authors is for all children to be given the opportunity to achieve their best potential, to grow to "freedom and fulfillment" through happy, creative living. They stress that parents must work toward these ends, selflessly devoting themselves to their children, giving them love and guidance, and helping them achieve healthy independence and the strength to stand firm against mass pressures for conformity and to work for peace and service to humanity. In the background there hovers always the group's awareness of the growing threat of delinquency and emotional illness, which makes them stress again and again the need for parents to have the "right" understanding and approach to their children in order to prevent "this tragedy of human break, waste, and suffering."

Few people would question these goals. While one may differ with the authors in evaluating the extent of the current chaos and confusion to which families are exposed, one must agree that parents play an essential role in fostering certain aspects of a healthy personality, such as responsibility, independence, respect for others. The question is *how* can this be done?

Here the book is disappointing. It is full of generalities, repeated in various ways, with most of which one would agree, but only occasionally do the authors introduce specific material out of everyday experience to illustrate their points. When they do, the book comes to life, bringing the reader out of the rarefied atmosphere of intellectualized concepts to a closeness with real children.

Children's Shifting Needs

While the generalized pronouncements apply to children throughout their growing up, the examples given are largely drawn from the preschool years. Nothing is said of the way in which children's needs shift as they meet new phases of growth through the school years and adolescence. There is no recognition of the differences in parental reactions to children at different phases nor of the varieties of parental responses to characteristic behavior of children at a stage in growth. So absorbed are these parents in their dedication to the goal of a special way of life that it is as if they felt that this required one approach, one way of dealing with children, regardless of their age, stage of development, or temperament. In their preoccupation with spiritual and philosophical goals, the authors have overlooked the need to describe in any detail the way one must adjust one's demands to the capacity and readiness of the children themselves.

I have used the word "demands" advisedly, for in

a strange way they are what these parents seem to present, under the guise of "guidance and direction." Their expectations of children seem both idealistic and unrealistic, as do their expectations for themselves. Can children be expected always to move steadily forward on the path to maturity, to learn to live selflessly? And will the ever-constant guidance of parents be the all-determining factor in helping children achieve these ends?

Growth Is Uneven

Children, by and large, do not move ahead in this way; their development is uneven, with spurts and plateaus and occasional backslidings. The reasons for this are not clear; they probably have to do with such matters as the children's psychological and emotional readiness in one area or another, and with their complex feelings about themselves and others. These variations of mood, interest, and capacity interfere with a child's steady response to guidance, and for many children tend to block the "training for habits" constantly referred to in this book, an emphasis which is reminiscent of the behaviorist approach of a generation ago.

Furthermore, while children have a strong, natural push toward growing up and doing what is socially acceptable, they also normally experience many negative, hostile, aggressive feelings, depending on their place in their family drama and the specific circumstances of their individual lives. That these negative feelings are present to some extent in all children, this book does not recognize. Where the authors do find such feelings, they see them as something evil and ominous and say they should not have been "allowed" to develop. They do not see them as part of all children's feelings, which children must learn to accept and cope with, to control and sublimate, so that they will take their proper place in the total personality functioning.

In their emphasis on the omnipotence of parents, the authors fail to recognize that parents are apt to become burdened and lose their spontaneity if they are told in no uncertain terms that "the smallest things we do loom tremendous in size and importance to the infant" or "we teach the child each moment of his life." Without conclusive proof on either side, experience has led to the growing belief that each act is not important by itself. It is the basic feeling between parent and child that counts and that helps many different experiences fall into place.

Moreover, the child's personality growth depends on much more than "what we [the parents] do with this [his] potential." It is influenced by many other forces within himself and in his world—the school, his friends, the church, the community, including all the mass media. In their very disapproval of movies, records, radio, and television, for example, which, they say "have a tendency to inhibit the child's creative power while arousing an appetite for overstimulation," the authors recognize the impact of forces outside the home. It is extremely doubtful that adolescents can close their minds to the force of other influences, and that they will accept the directives of their parents as readily as suggested in the following passage:

"As we teach him [the adolescent] health habits and attitudes, we begin teaching him, according to his age and understanding, the poisonous effects of nicotine and alcoholic beverages. With learning thus ingrained he will never have the desire to acquire such harmful habits."

Facts and Values

In a number of places, the authors negate sound and valid concepts by dogmatic, oversimplified statements about matters on which they have strong biases—for example, the values of natural "health" foods, a vegetarian diet, and sunbathing, and the bad effects of noise on infants. If books for parents are to be helpful, the facts they contain must be in line with the best scientific knowledge of medicine and psychiatry, child development, education, sociology, and cultural anthropology. They should take cognizance of new facts or new interpretations of facts to help parents take a new look at their children and themselves.

"New looks" often open the way for parents to find themselves having new feelings and trying different ways of dealing with their children. Parents respond to the challenge of new values and goals, but they do this best if they are not oppressed by such an exaggerated sense of their own role that they are kept from the kind of learning with their children that this book so well describes—learning together in the normal, easy give-and-take of a family's growing-up.

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[1] Cooperative Parents' Group of Palisades Pre-School Division & Mothers' and Children's Educational Foundation, Inc.: The challenge of children. New York: Whiteside and William Morrow & Co. 1957. 191 pp. $3.75.

BOOK NOTES

THE AMERICAN TEEN-AGER. H. H. Remmers and D. H. Radler. Bobbs-Merrill Co., New York. 1957. 267 pp. $3.75.

A collaboration between a sociologist and a journalist, this book not only presents the results of a 15-year nationwide study of the opinions of high-school students on many of their problems, but also a good many of the authors' own opinions on how parents and other adults should deal with them.

In carrying out the study the Purdue Opinion Panel, a part of Purdue University's Division of Educational Reference, of which Dr. Remmers is director, gathered teen-agers' opinions through tests and questionnaires, supplemented by letters voluntarily contributed by participants in the polls. The size of the sample of the population polled varied in the different years from 8,000 to 18,000, and was controlled only with respect to age, sex, grade, and geographical region. Random sampling was depended on in regard to income level, religion, and parents' age and education.

The questionnaires were devised to inquire into the attitudes of teen-agers regarding: the physical changes of adolescence; sex relationships; adjustment to the world outside the home; adjustment of relationships with their parents; formal education and extracurricular activities in the school; decisions regarding college education; choice of a career for the future; preparation for marriage; questions concerned with the functions and practices of religion; and responsibilities and problems of citizenship. The book presents results of the polls in tabular form, gives the authors' interpretation of their meaning, illustrates this with many excerpts from the teen-agers' letters, and moralizes somewhat on how problems might be lessened or avoided. One of the most prominent characteristics of the teen-ager, according to the study's findings, is the tendency toward conformity.

The authors suggest that youth be trained and encouraged to use the scientific method of inquiry to solve their problems. They also suggest that we will develop citizens capable of functioning effectively in a democracy by paying more attention than we do now to the 97 percent of our teen-agers who are not delinquents and by not restricting our activities to contending with the 3 percent who are.

FAMILY MEDICAL COSTS AND VOLUNTARY HEALTH INSURANCE: a nationwide survey. Odin W. Anderson and Jacob J. Feldman. Foreword by Franklin D. Murphy. McGraw-Hill Book Co., New York. 1956. 251 pp. $6.50.

This book presents information on enrollment in voluntary health insurance in the United States; charges for personal health services and distribution of such charges; use of hospital care and of surgical and other services; and types of insurers. The data are based on reports of single interviews held in 1953 with 2,809 families including 8,846 individuals, chosen as a sample of the country's population. The sample was drawn by the methods used by the United States Bureau of the Census in its current population surveys.

Among other findings the book reports:

Women of childbearing age, 18–44, who make up 20 percent of the United States population, incurred 28 percent of the charges for personal health services. Maternity care accounted for 18 percent of all hospital admissions, 29 percent of all hospital admissions of women, and 60 percent of the admissions of women 18–34 years old.

Children under 6—an age group constituting 13 percent of the United States population—incurred only 6 percent of all charges for personal health service; children under 18—an age group constituting 31 percent of the population—incurred 18 percent of such charges.

The survey was made by the Health Information Foundation, with technical assistance from the University of Chicago's National Opinion Research Center.

TREATMENT OF THE CHILD IN EMOTIONAL CONFLICT. Hyman S. Lippman. McGraw-Hill Book Co., Blakiston Division, New York. 1956. 298 pp. $6.

The author, who is director of the Amherst H. Wilder Child Guidance Clinic, describes methods of applying some of the features of child analysis to the treatment of large numbers of emotionally disturbed children seen individually once a week.

Stressing that effective treatment varies, not only with the therapist but with the needs of the child, he recommends that therapy be given to children whose behavior cannot be controlled by their parents, teachers, or others in authority; neurotic children whose anxiety is great enough to produce serious suffering in themselves and others; children who in spite of normal ability have learning problems; and unstable, immature children who cannot deal with reality without help from others.

The author notes that most communities lack the resources for helping emotionally disturbed children, such as psychiatric clinics, foster homes, residential-treatment centers, and therapists in institutions for delinquents. As a step toward prevention, he recommends earlier and more intensive social service to disorganized families, through reduction of family-service workers' caseloads to 30 families each.

GROWTH, TEACHING, AND LEARNING: a book of readings. Edited by H. H. Remmers, Harry N. Rivlin, David G. Ryans, and Einar R. Ryden. Education for Living Series. Harper & Bros., New York. 1957. 557 pp. $4.50.

More than 60 papers, reprinted from various professional journals, are presented in this book, which is addressed to "teachers of prospective teachers." It is divided into three parts: The Growing Child; Emotional Development and Mental Hygiene; and Measurement, Evaluation, and Research Techniques in Educational Psychology.

IN THE JOURNALS

Children and Suicide

Why children commit suicide is discussed by Harry Bakwin in an article presenting material from a number of American and foreign sources, published in the June 1957 issue of the *Journal of Pediatrics*. ("Suicide in Children and Adolescents.")

Noting that annually in the United States more than 35 children 10–14 years of age and more than 200 adolescents aged 15–19 commit suicide the author urges that efforts be made to recognize the child susceptible to suicidal ideas.

Among children, as among adults, suicide is more common in males than in females; in whites than in nonwhites; and in urban residents than among rural, the author notes. Also the seasonal variation is the same as for adults—the highest point in May and the lowest in December.

In both young children and adolescents fear of punishment, remorse, shame, guilt feelings, and anger are frequent causes of suicide, the author points out. Adolescents are influenced also by feelings of inadequacy and of exclusion, and problems of sex adjustment. Mental illness accounts for only about 10 percent of suicides in the young.

Parent Discussions

During the past winter a group of parents, who had been reported to the Jefferson County Welfare Department, Louisville, Ky. for neglect or abuse of their children met in a neighborhood house twice a week for 6 months to discuss together their problems in child rearing, with one of the department's caseworkers as volunteer group leader. The project is described by Jane McFerran in the July 1957 issue of *Child Welfare* ("Parent Discussion Meetings —A Protective Service Agency's Experience.")

Attendance at the meetings, always voluntary, grew from 3 to 4 persons at the first few meetings to a core group of 13. Visits and letters from caseworkers, scheduling the meetings at night, and the securing of financial help from a church group to pay for babysitters and transportation facilitated attendance. The department plans to begin a second series of meetings this fall.

Treatment in School

Guidance treatment given in an elementary school to extremely aggressive children living in one of New York City's deprived neighborhoods is described by Joseph Rosner in the April 1957 issue of the quarterly *American Journal of Orthopsychiatry*.

The school that gives the treatment is one of the city's six public "all-day neighborhood" schools, which are open from 7:45 a. m. to 5 p. m. Most of the pupils are "latchkey" children, who let themselves into empty homes after school because both parents are away at work. About 10 percent of the school's 1,500 children receive the special services of a social worker-psychologist-psychiatrist team. Some of the children are so disturbed that they seriously injure other children in outbursts of violence.

Children in trouble are referred to the social worker, who sees them in a private office. The psychologist spends one day a week in the school; and a neighborhood psychiatrist heads the treatment team. Community resources such as clubs and camps are also called upon. Classroom teachers, special leaders, the principal, the school custodian, lunchroom attendants, school nurse, and other school personnel all work cooperatively in efforts to help individual children.

Vaccination Against TB

In spite of the dramatic decline in tuberculosis mortality in the United States in recent years, vaccination against tuberculosis is needed in this country because the number of newly reported cases remains high, according to a report by the Medical Advisory Committee of Research Foundation, published in the *Journal of the American Medical Association* for June 29, 1957. ("Why Have We Not Accepted BCG Vaccination?")

The safety of BCG [the vaccine prepared from Bacillus Calmette-Guerin] has been tested by means of millions of vaccinations in many countries, the report says, pointing out that the introduction of the multiple-puncture method of administering it has practically eliminated the danger of complications.

The report refers to results of recent studies of vaccinated and unvaccinated groups of children over a 4-year period, which show, on the average, an 80-percent lower incidence of tuberculosis in the vaccinated than the unvaccinated.

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Data on mass campaigns against tuberculosis in three continents, begun in 1951, are published in the *Chronicle of the World Health Organization* for May 1957. ("BCG Vaccination Programmes, 1951–56.") Up to January 1, 1957, the report says, the World Health Organization and the United Nations International Children's Fund had assisted the governments of 38 countries and territories, with a combined population of about 775 million, in carrying out BCG-vaccination campaigns, in which 162 million people were tuberculin-tested and 60 million vaccinated.

In the 17 countries where the campaigns have been completed, 20 percent of the persons tested were under 7 years of age; 39 percent were 7–14 years of age; and 41 percent were 15 years of age or over. The average age distribution among those vaccinated was: under 7 years, 32 percent; 7–14 years, 46 percent; 15 and older, 22 percent.

Heredity or Environment?

Interdisciplinary longitudinal studies of the growth and development of twins, beginning before their birth and carried on for many years with rigid scientific standards are urged by Frank Falkner in *Eugenics Quarterly* for June 1957. ("The Potential Contribution of Longitudinal Twin Studies; an appraisal.")

Warning against unscientific approaches, which, he maintains, have done "great harm" in the past the author recommends a collective approach to efforts to unravel genetic, physiological, and psychological influences on the human constitution. Such an approach, he suggests, would involve the use of psychological, anthropometric, biochemical, photogrammetric and radiological measurements, and volumetric estimations.

PROJECTS AND PROGRESS

Radiation

In a statement issued last March, the United Nations Scientific Committee on the Effects of Radiation asked the medical profession in each country to forward information through appropriate government channels on how the hazards of medical X-ray might be minimized and for an estimate of the total radiation to the gonads received by the population before and during the reproductive age. Maintaining that prudence calls for limiting the average dose to germinal tissues from artificial sources to an amount equal to that received from natural sources, the committee asked radiologists to suggest ways of reducing exposure from diagnostic and therapeutic X-rays.

Established in 1955 by the U. N. General Assembly, the committee, consisting of scientific delegates from 15 nations, is collecting information on the amount of radiation to which man is exposed from all sources. It has reported that information received thus far indicates that in two countries, Sweden and the United States, irradiation from diagnostic procedures comes to at least 100 percent of all natural radiation.

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In the United States various studies are now underway at universities and medical institutions to determine the amount of irradiation received by tissues in the course of medical and dental X-rays. Among those financed by the National Institutes of Health, Department of Health, Education, and Welfare, are:

1) A study to investigate the exposure of the public to radiation in medical procedures, which will apply measurement techniques to determine the skin and gonadal dose received, collect and analyze nationwide statistics, develop improved instrumentation, and test questionnaires designed to elucidate information on individuals' experience with X-rays;

2) a study to develop a system of determining quickly the irradiation dose in tissue at any depth or distance from the source of radiation so that through the analysis of data thus gathered it will be possible to relate dosage to immediate and latent effects of irradiation;

3) a study of the association or relationship between irradiation of the thymus and other organs to development of cancer, which is expected to provide further information as to the existence of a threshold dose for the production of neoplasia.

Among other studies now underway are one to determine the X-ray dose to the gonads of children and adults during various diagnostic procedures and one concerned with the development of a unit for dental X-ray apparatus designed to reduce the amount of X-rays received by the tissues of both patient and operator.

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The U. S. Department of Labor recently amended its hazardous-occupations order No. 6, which under the Fair Labor Standards Act sets 18 years as the minimum age for workers in certain occupations involving exposure to radioactive substances. The amended order includes additional conditions that the department declares to be particularly hazardous for minors under 18. These are exposure to radioactive substances in the air and to ionizing radiations, either or both in excess of a specified percentage.

Against Polio

More than 99 percent of the $53,600,000 appropriated by Congress for a 2-year period to help provide poliomyelitis vaccine for children had been paid to States and Territories at the time the law establishing the program expired on June 30, 1957, according to the Public Health Service, Department of Health, Education, and Welfare. The grants were made for the purchase of vaccine and the administration of polio-vaccination programs for children and young people under 20 and for pregnant women.

It is estimated that by the time all the vaccine ordered under the provisions of the law has been used, about 29 million children and pregnant women (45 percent of the population in these groups) will have received a total of over 75 million injections through the federally financed program. This program has supplemented State, local, and private efforts to finance vaccinations, which are continuing.

Four States—Arkansas, Indiana, Nebraska, and Wyoming—did not use all their Federal allotment. The balance of unspent allotments, about $400,000, reverted to the United States Treasury.

Polio-vaccine inventories in the hands of manufacturers, druggists, physicians, and health officers "remained low during the summer, making it necessary for communities to time their vaccination drives in relation to the availability of supplies."

The Public Health Service collects data on the distribution and use of vaccine each week to assist manufacturers in planning distribution and to aid local groups in planning and carrying out their vaccination programs. The data are also transmitted to the American Medical Association, the National Foundation for Infantile Paralysis, and the Association of State and Territorial Health Officers.

Protective Services

No protective-casework services for neglected children are available in many parts of the United States, according to results of a 20-month nationwide study made recently by the American Humane Association.

Existing legislation in more than two-thirds of the States permits the State and local public welfare agency to provide protective services, and some such service is provided in nearly all of these States. Ten States have some services provided by both public and voluntary-agency services; 24 have public services only; 6 have voluntary only; and in 8 neither public nor voluntary services of this type are available.

A total of 81 voluntary agencies—three-fourths of them in New England and the Middle Atlantic States—reported that they provided child-protective services. In 32 States no voluntary agency provides such services.

The Association's questionnaire, addressed to more than 800 community chests and councils, to State departments of public welfare, and to county departments that administer child-welfare services, identified the services to be reported as specialized casework

services, provided before any court action is taken and geared to rehabilitation of the child's home through treatment of the motivating factors which underlie neglect.

Training

A year-long program to provide preparation to houseparents in children's institutions is being offered by Saint Louis University's School of Social Service. The program, called the Institute of Child Care, includes a course of classroom instruction in such subjects as child development, dynamics of group living, and emotional problems of children; 5 months of supervised practical experience in an institution; and a 4-month seminar at which institutional practices and programs are discussed. No college credit is granted, but a certificate is awarded to students who complete the full year, including the field experience.

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Michigan's State Department of Social Welfare recently launched a comprehensive staff-development program in cooperation with juvenile-court judges and probation officers. The plan includes the granting of educational leave, provision of special courses by graduate schools of social work, and the holding of workshops and seminars for probation officers.

Physically Handicapped

Public announcement has only recently been made of the World Rehabilitation Fund, a voluntary organization, with headquarters in New York, formed in 1955 to stimulate international understanding of projects for rehabilitation of the physically handicapped. Among the projects it has already sponsored are: provision of artificial limb components to the Philippines and Thailand; assistance for study in the United States by physicians and other rehabilitation personnel from Haiti, Greece, Great Britain, Thailand, Poland, Belgium, the Philippines, and Brazil; provision of periodicals and books on rehabilitation to France, Poland, Russia, the Philippines, and Australia; and sponsorship of rehabilitation demonstrations and conferences in Cuba, Indonesia, India, Denmark, Guatemala, Switzerland, Great Britain, and the United States.

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A 10-month comparative study of the education of handicapped children in 15 European countries was recently begun under the sponsorship of the International Society for the Welfare of Cripples, with the cooperation of the International Union for Child Welfare.

The data collected will be used by the society to improve the program of its committee on education of crippled persons. The committee, which is composed of experts from eight nations, was established in 1955 to collect and disseminate information and make recommendations concerning academic education and vocational training for physically handicapped persons.

Two college professors on leave from their universities are collecting the data without compensation. They will visit institutions in Austria, Belgium, Denmark, England, Finland, France, Ireland, Germany, Greece, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and Yugoslavia. They may also visit institutions in Czechoslovakia, Poland, and the Soviet Union. Grants to finance their itinerary have been received by the society from the World Rehabilitation Fund, the Association for the Aid of Crippled Children, and the National Foundation for Infantile Paralysis.

Vital Statistics

According to provisional data from the National Office of Vital Statistics, U. S. Department of Health, Education, and Welfare:

An estimated 108,300 deaths of infants under 1 year of age in the United States were registered in 1956—a rate of 26 deaths per 1,000 live births. The largest drop in rate took place in deaths from an important cause, "immaturity, unqualified," the rate for which decreased from 5.3 per 1,000 live births in 1955 to 4.9 in 1956.

The Children's Bureau estimates that in 1955 about 310,000, or approximately 7.6 percent of the more than 4 million infants born alive in the United States, were premature babies—infants weighing 2,500 grams or less at birth. A larger proportion of the infants born to nonwhite mothers (11.7 percent) were in this low-weight group than of those born to white mothers (6.8 percent). These figures are based on information taken from live-birth certificates. Birth weight was recorded on the certificates of 95 percent of the infants.

Certificates of fetal death also carry space to record birth weight, but in 1955 one out of four death certificates filed for fetuses 20 or more weeks in utero were incomplete in this respect. It is estimated that 60 percent of the infants that died before or during birth in pregnancies of 20 or more weeks' duration weighed 2,500 grams or less at birth.

Juvenile Delinquency

The Federal Bureau of Investigation reports that 17.3 percent more young people under 18 were arrested in 1956 than in 1955, while the population 10–17 years of age rose less than 3 percent. Arrests in the under-18 group rose 20.9 percent in cities with fewer than 25,000 inhabitants; in larger cities the rise was smaller—16.5 percent.

Of persons under 18 arrested in 1956, 40.1 percent were not yet 15 years old; these younger children accounted for one-fifth of the arrests for stealing automobiles.

Mental Retardation

More than half of the 70 cooperative educational-research projects launched with the help of Federal funds during the past year are in the field of mental retardation, according to the Office of Education, Department of Health, Education, and Welfare. The projects on retardation, now being carried on by colleges and universities and State educational agencies in 16 States, are investigating various conditions related to the education of the mentally retarded, such as emotional reactions to learning; hyperactivity; reasoning ability; sight and hearing; social behavior; motor characteristics; speech correction; attitudes of parents; services in sparsely populated rural areas; and the merits of various teaching facilities, such as ordinary school classes, special day classes, and State residential schools.

Among the other subjects being studied under the cooperative research program are the effects of migration on children's education; school vandalism and other delinquency; dropping out of high school, especially when the student has college capacity; social adaptation of the gifted adolescent.

. . .

Twenty-seven State plans for special projects in the field of mental retardation have been approved for Federal funds by the Children's Bureau for the fiscal year ending June 30, 1958.

In most of these projects children are

to be served directly by State or local staff. Some projects train professional personnel; others aim to find new ways to provide services to rural areas.

Clinical services provide basic pediatric care with emphasis on early diagnosis of the child's condition, evaluation of his potentialities, and planning for his training. They also provide followup services, stressing home training and calling on the resources of health-department personnel, especially the public-health nurse. In most projects the clinical team is directed by a pediatrician and includes a social worker, a psychologist, and a pediatric nurse; while some include additional specialists such as a psychiatrist and a child-development worker.

Rural Health

An extensive study of health needs in sparsely settled rural areas was begun July 1, 1957, by the Public Health Service, Department of Health, Education, and Welfare. The study is designed to help find effective and economical methods of bringing modern public-health services to people in the less populous areas of the United States.

The study, which began with an exploratory survey of the health situation in Kit Carson County, Colo., will be extended to other counties in the Great Plains area. This area was selected for study because it has few local health departments, because it is a farming country with a widely scattered population, and because drought and other severe weather conditions have affected farm incomes.

More than 1,500 families in Kit Carson County will be interviewed. The Colorado State Department of Health, local physicians, and county leaders are cooperating in carrying out the study.

* * *

The Commonwealth Fund has recently reported on a cooperative project through which medical and other organizations helped a number of isolated communities in a worked-out mining area on the Tennessee-Kentucky border to achieve health and medical facilities that were entirely lacking several years ago. These include two community diagnostic and treatment clinics and two hospitals built with community funds supplemented by State and Federal money provided under the Hospital Survey and Construction (Hill-Burton) Act.

In 1952, at the suggestion of the United Mine Workers, the American Medical Association and the Tennessee, Kentucky, and West Virginia medical societies joined in planning for improvement of health conditions in the area. With a grant from the Commonwealth Fund and contributions of money and personal services from many organizations and individuals, including residents of the area, a foundation established by the Tennessee State Medical Association surveyed the area's problems and possibilities and worked to establish facilities to meet long-range needs, to develop types of service suited to each community's health requirements and economic resources, to curb costly mistakes, and to help the people and the medical profession to join forces for the health of the community.

The report, which was prepared by William A. Massie, has been published by the Harvard University Press. (Price $1.25.)

CB Appropriations

The 85th Congress has appropriated $41,500,000 for grants to the States for the fiscal year ending June 30, 1958, under the three grant programs administered by the Children's Bureau (Public Law 85-67, approved June 29, 1957) an increase of $2,139,000 over the 1957 appropriation. This year's appropriation includes $16,500,000 for maternal and childhealth services, $15 million for crippled children's services, and $10 million for child-welfare services. Of the increase, $500,000 is for maternal and child-health services and $1,639,000 for child-welfare services. The MCH and CC appropriations equal the full amount authorized by the Social Security Act, as amended; the sum appropriated for CWS is five-sixths of the amount authorized.

As in the previous year's appropriation, $1 million of the grant for maternal and child-health services is earmarked for special services for the mentally retarded.

For Children's Bureau salaries and expenses, the amount appropriated is $2 million, an increase of $178,000 over last year's. Of this new fund, nearly $100,000 is required for contributions to the civil service retirement fund, as specified by recent legislation. The remainder of the increase will make it possible for the Bureau to begin planning for the 1960 White House Conference on Children and Youth and to strengthen somewhat its activities in relation to juvenile delinquency, research, and child-welfare services.

Census Figures

According to recent estimates of the Bureau of the Census:

The total population of the country, including Armed Forces overseas, was about 170,510,000 April 1, 1957. This figure represents an increase of 12.8 percent since April 1, 1950, and of 1.8 percent since April 1, 1956.

Two million married women in the United States with children under 6 years of age—16 percent of all such women—were employed or seeking employment in 1956. This proportion, which had edged up from 11 percent in 1948 to about 16 percent in 1953, remained relatively stable in the years 1953–56. On the other hand, the rate for married women with no children under 6 years continued to push upward almost without interruption after 1948, when it was 28 percent, and reached a high of 36 percent in 1956.

At the beginning of the 1956–57 school year, about 40.3 million persons were attending school in the United States. Of these, 1.8 million were in kindergarten, 26.2 million in elementary school, 8.5 million in high school, 2.9 million in college or professional school, and 900,000 in trade or business school.

More high-school and college students were employed outside school hours in 1956 than in any previous year since World War II.

About Courts

A new Montana law requires every county judge to appoint a juvenile-court committee to confer with the judge, when called by him, on all matters pertaining to the juvenile department of the court and to act as a supervisory committee for detention homes and the selection of foster homes.

* * *

The National Probation and Parole Association, in cooperation with the State board of public welfare and the State youth commission, recently completed a study of North Carolina's juvenile courts and probation services. The study was financed partly by child-welfare-services funds provided under the Social Security Act. The association recommended that the State establish a family-court system and a separate statewide probation service.

READERS' EXCHANGE

DAVIDSON: *Why not here?*

I read with interest Dr. George Davidson's article, "Canada's Family Allowances in Retrospect" (CHILDREN, May–June 1957). Despite the absence of absolutely conclusive proof, it is difficult to believe that such a sizable redistribution of income as the family-allowance program brings about in favor of children in the less comfortable income brackets is not a major contribution to the well-being of the Canadian nation. This raises the puzzling questions: why is there so little interest in children's allowances in the United States? and why, in particular, do social workers seem so indifferent to the potentialities of a social instrument that is now used in over 35 countries?

It can scarcely be that no children are in need in the United States. Nor does the logic of arithmetic cease to apply in this country. Since the majority of children are found in the larger families and since an income of any size yields a smaller amount per family member the larger the family unit sharing it, the majority of children live on a lower economic level than the children of small families. Some are desperately poor. Perhaps what calls for explanation is that more publicity is not given to the standards of living of children according to size of family. Sheer poverty as a major social problem seems to have taken second place in the minds of those who are professionally concerned with social welfare in favor of a concern about emotional security.

In fairness to social workers in this country however, it must be admitted that in other English-speaking countries children's allowances were less the result of active agitation on the part of social workers than the almost inevitable outcome of certain other social policies as in Australia and New Zealand and even England or the by-product of a particular social climate.

In England the program was adopted during the war when feelings of national solidarity ran high and there was a general commitment to a postwar world in which gross economic inequalities would be eliminated. In Canada, too, as Dr. Davidson shows, children's allowances were instituted as part of an overall postwar plan, although primarily for their economic, rather than their strictly social, effect.

It is perhaps too much to expect any great enthusiasm for such a program in the United States today. There is no lively passion for economic equality: indeed, the country as a whole has accepted with great complacency for over 20 years the relatively shabby treatment of children in the ADC program. Welfare programs in general appear to be regarded by many persons as the marginal claimants on tax money. The admittedly high cost of children's allowances must thus often appear as a possible threat to adequate appropriations for existing welfare measures which are presumably regarded as being of greater urgency.

To say that the social climate of the United States is today unfavorable to the idea is not to condone inactivity on the part of those of us who regard children's allowances as one of the major social inventions of the 20th century. For unless we do more to publicize both the economic needs of children and the potentialities of the children's allowance programs, the prevailing complacency will never change.

Ereline M. Burns
Professor of Social Work, New York School of Social Work, Columbia University

CLOSE: *Open doors needed*

Working on behalf of the mental health of the Hungarians in Austria, we have been very much interested in Kathryn Close's article on the Hungarian refugees in the United States because it gave us a clear picture of what is happening at the receiving end of a process which we saw initiated here. (See "Speed in Resettlement—How Has It Worked?" CHILDREN, July–August 1957.) We hope similar reports will be available from other countries of second asylum.

There remain about 30,000 Hungarian refugees in Austria, the majority of whom wish to emigrate. Among these a most particular problem is the unattached youth, of whom there are almost 2,000 in youth homes, schools and refugee camps. Most of these 14- to 18-year-olds are projecting their wishes toward emigration, many toward the U. S. A. The uncertainty of their fate because of the lack of emigration possibilities is causing a dangerous mental situation for these young people, as well as for the adults. This is enhanced because so many of their age group, selected largely by chance, are already starting new lives in other countries.

The Ministry of the Interior, which has responsibility for all refugees in Austria, is establishing a number of schools for the vocational training of the young refugees. The teenagers have been transferred from the camps to these youth homes and will have the opportunity to have busy hands while awaiting the dreamed-for day of emigration.

The most important thing as we see it in our daily contacts with these refugees is for some of the doors of other countries which have been shut in their faces to be opened again to allow them, if they stay in Austria, to do so by free choice and not to be forced to stay by circumstances beyond their control. For 12 years the Hungarians have been unable to exert control over their own lives and now even in their escape it looks as though major decisions affecting them will be made without their participation.

One of the main difficulties still with us and to which Miss Close refers in her review of the situation in the United States is the lack of understanding of the need for getting accurate and timely information to the refugees over every step of the way. The fact that "there is no information" may be important information in itself for the refugees to know. The lack of information about the procedures for clearance for emigration to America, as an example, has not only caused endless hard feelings toward the United States among the refugees, but has also caused them severe emotional and social disturbance.

We think it very necessary to point out to all concerned with refugee work in any place in the world that people live not only by bread and blankets but have mental and psychological needs which must also be provided for from the moment of emergency reception through the time of resettlement in the

country of final asylum. Real assimilation can be achieved only when there is insight into the psychology of the refugee and an understanding of mental health concepts.

Almost all aspects of the refugee's life are connected with his special psychological and sociological situation. Mental health workers, in coping with the emotional problems, must sometimes make recommendations in fields which may seem far out of their scope, but which, nevertheless, affect the mental health and stability of the refugee.

The Work Group for Refugees of the Austrian Society for Mental Health, Vienna, Austria

Hope for refugees

May we add a postscript to the article on Hungarians on the bridge of hope erected hastily—but efficiently—by the 27 nations, including the United States, banded together in the Intergovernmental Committee for European Migration (ICEM).

Since November 4, when the Austrian Government first appealed to ICEM to coordinate the resettlement of the swelling numbers of Hungarian escapees, 142,054 have been resettled in 36 countries, including 33,281 in the United States. (The present Hungarian refugee population in Austria is about 29,000.) This achievement, within 8 months of the crushing of the revolt, could have come about only by a dramatic mobilization of resources, both spiritual and material, by member and nonmember nations of ICEM.

First, ICEM addressed appeals to Western governments, which resulted in prompt offers of asylum and relaxed immigration standards. Within hours, ICEM teams were at the border, in the camps, and in Vienna, registering, documenting, processing, and transporting the refugees. Buses and trains, commercial and military ships and planes were pressed into service by the organization to carry escapees to other European countries and to overseas destinations.

After tackling the Austrian influx, ICEM was authorized in mid-April of this year to work in Yugoslavia, to help plan emigration for some 16,600 Hungarians who had escaped into that country. By July 5, 7,500 had been moved to other countries. Nearly 10,000 are still awaiting resettlement.

Our dependable allies throughout the program have been the voluntary agencies.

R. L. Beukenkamp
Chief, U. S. Office, Intergovernmental Committee for European Migration

The longer pull

I would like to offer a few observations from the standpoint of an agency not associated with the more highly publicized parts of the Hungarian refugee operation described in the July–August issue of CHILDREN.

Once again we see a situation in which public interest and outpouring of funds is largely used up on the emergency or what we sometimes refer to as the "penicillin and blanket phase" of refugee operations. I would not wish to detract from the excellent work that is done by other organizations or individuals in dealing with this kind of emergency, but I believe we have still not found a way to sustain these efforts until the total problem is dealt with. For example, there are still approximately 2,700 unaccompanied Hungarian young people remaining in Austria and adjacent countries.

The International Social Service, in cooperation with the United Nations High Commissioner for Refugees, is undertaking the task of counseling these young people and attempting to help them find a solution at this critical stage in their lives. This requires the best skills the field of social service can supply in dealing with some difficult and complicated personal problems for which months will be required for finding a satisfactory solution.

There are, of course, also thousands of families left in both Austria and Yugoslavia who are already beginning to take on the signs of discouragement and defeat all too familiar in thousands of other people left in refugee camps in various parts of the world. There are also hundreds of family separation cases still awaiting a final solution in all of the countries that accepted people in the emergency.

In its 36 years of experience ISS has seen this pattern many times. When the disaster first strikes there is a warm outpouring of sympathy and help. The real problem is how to sustain efforts over the longer pull. Many of us have witnessed the operations of UNRRA and IRO and are aware of the present valuable programs of the ICEM and the United Nations High Commissioner for Refugees. No one can be sure when the next emergency will arise.

I believe the time has come for appointment of a special Presidential commission to study the total problem of international refugee and relief efforts and the position that our Government should take with regard to intergovernmental organization in this field. A crisis-to-crisis approach is inadequate and no longer warranted.

The voluntary agencies have made significant contributions. It would be no more possible solely with contributed funds to meet these problems than it would be for any major American community to handle its public welfare program by passing the hat. The voluntary agencies can make their best contribution when they can relate to a single, well-coordinated intergovernmental program. Without this, there will always be a magnificent sprint for the first few hundred yards without the staying power to finish the mile that needs to be run.

William T. Kirk
General Director, American Branch, International Social Service

BOOLE: *Reply to critic*

In her comments on my article, "Unmarried Mothers in Hospitals," in the November–December 1956 issue of CHILDREN, Genevieve Short raises a well-taken question about the role of the medical social worker as I described it. (Readers' Exchange, CHILDREN, January–February 1957.) I agree that the social worker should try to evaluate the individual as a potential parent and that at times should say in effect to the natural mother, "I think you should give up your baby," or "I think you should keep your baby." However, I believe that such counsel should come only after careful study and evaluation of the complex situation. If the mother's decision is contrary to the judgment of the social worker, that decision still must be respected unless the situation is of such serious proportions as to warrant referral to an authoritarian agency such as the juvenile court.

The whole matter of values as to who will make a good parent is still ill-defined. What are our standards for evaluating the advantages and disadvantages of a child's remaining with its natural mother or being placed with

an adoptive one? It seems to me that we need studies conducted over a long period of time to gain better understanding of the best way to assure healthy emotional adjustment for a child born out of wedlock.

The article attempted to deal with our concern about the doctor, the medical student, the nurse, the ward secretary, who are not trained in the recognition of their subjective feelings and the extent to which these feelings influence their approach to the problem. Oftentimes members of the hospital staff in intimate contact with the patient will give didactic advice to give up or keep a baby on the basis of their own feelings. They are not in possession of all the facts about the mother's situation, are not trained in evaluation of her personality, and do not know the extent of the counsel which has been given by qualified people. It is this projection of feeling which we try to handle by the various means outlined in the article.

As I reread Miss Short's letter, I find that I am not clear about the social worker's course after having made her evaluation of the mother's personality. Suppose that their ideas about what should be done differ—then what?

Lucile G. Boole
Principal Medical Social Worker, Social Service Department, University of California Medical Center, San Francisco.

SHERIDAN AND BREWER: *Helping through the court process*

It is with interest that I read the thoughtful examination of some of the sociolegal problems involved in the family-court concept. ("The Family Court," by William H. Sheridan and Edgar W. Brewer, CHILDREN, March–April 1957.)

Of particular interest was that portion of the article which dealt with marriage counseling in matrimonial actions. Essentially, as I understand it, the authors distinguish between marriage counseling *per se* and using the steps of the court's process as a means of helping the petitioner and respondent come to grips with the problems divorce entails. I am generally in accord with this point of view, but feel there is even more to be gained by the distinction than the authors point out.

While I agree that marriage counseling as such should be placed outside the court, I believe the court can so define and use its procedural steps that a helping process takes place in relation to the marriage relationship even though the focus is on the divorce. The authors suggest these procedures should provide for exploratory interviews with the twofold purpose of acquainting the spouses with the personal, economic, and social problems ahead of them and of providing them with information about community resources which might help with these problems. The real key to the nature of the process, however, is in their further statement that such is comparable to the preliminary screening at intake in the juvenile court.

Actually, the intake process in a good court can go beyond the twofold purpose already mentioned. It provides an opportunity for those concerned to put themselves and their problems against the community's concern as represented by the court, and to find a way, if they can, to take in that concern as expressed in the law and to find a new relationship to their problem. It may be, for example, that in bringing a matrimonial action to the court, the wife has determined there is no other solution to an intolerable situation. Yet as each step in the legal process unfolds, she can be helped to examine her need for a new and different sense of the problem she faces.

Essentially what is desirable is the same kind of involvement of the spouse that an applicant for foster-home placement experiences. The requirements of the placement process call for a testing out of the original solution and request. By setting conditions and requirements which involve the client the mother is enabled both to find out if it is what she really wants and, if it is, to get ready to use the placement as constructively as possible.

In other words, if each step in the court's process of handling matrimonial actions can be conceived of and carried out as a way of helpfully involving the spouses in a consideration of what they are doing and of their problems with it, the spouse will either affirm a decision to petition for divorce, or turn to another way such as marriage counseling for handling the problem. This is all that can be rightfully expected from either the client or the court. It involves no procedural or substantive rights of due process or any question of privilege, nor does it interfere with the role of the attorney or of other social agencies. Rather it provides for the kind of careful consideration that the law implies and the community expects when the matter of a dissolution of a marriage is to be acted upon.

C. Wilson Anderson, Executive Director, Family and Children's Service, Minneapolis

CORRECTION: *Citizens count, too*

In reading the very interesting issue of CHILDREN for May–June 1957, we noticed with a little concern the first item under "Adoptions" on page 115 in the Projects and Progress section.

We think it fair that the readers of CHILDREN should know that the California State Department of Social Welfare was only one of six groups which received the Marshall Field Award together. The groups were: The Adoption Survey Committee, the Citizens Committee on Adoptions, the Los Angeles County Bureau of Adoptions, the Rosenberg and Columbia Foundations, and the State Department of Social Welfare. Each of the participants had contributed to "the marked extension and increased services to children needing adoption" and received the inscribed scroll. By agreement the $2,000 was given to the Citizens Committee and the Los Angeles County Bureau of Adoptions.

There can be no question about the important contribution and continuing leadership of the State department of social welfare. However, one of the most important facts contributing to the decision of the Field awards committee was the participation of hundreds of citizens. The awards committee felt that this so-called package deal "demonstrated what can be achieved when private funds, citizen effort, and public administrative bodies work cooperatively for a sound social good."

Mrs. Leslie W. Gaupard
Executive Director, Rosenberg Foundation, San Francisco

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

PROGRESS OF PUBLIC EDUCATION IN THE UNITED STATES OF AMERICA, 1956-57. Department of Health, Education, and Welfare, Office of Education. 1957. 99 pp. 45 cents.

This report on education in the United States, presented in four languages—English, French, Russian, and Spanish—was prepared for the Twentieth International Conference on Public Education, which met at Geneva Switzerland, July 8–17, 1957, under sponsorship of the United Nations Educational, Scientific, and Cultural Organization and the International Bureau of Education. It summarizes 1956–57 facts on administration; organization; study plans, curriculums, and methods; teaching staff; auxiliary services; and research; and includes a section on cultivation of world understanding through education.

BASIC READINGS IN SOCIAL SECURITY; social welfare; social insurance. Compiled for the Social Security Administration by the Library of the Department of Health, Education, and Welfare. SSA Publication No. 28—1956. 1957. 144 pp. 50 cents. Single copies available from the SSA without charge.

A guide to significant books, pamphlets, articles, and current periodical sources on the Social Security Act and the programs administered under it.

PUBLICATIONS OF THE CHILDREN'S BUREAU, JUNE 1957. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1957. 35 pp. Single copies available from the Bureau without charge.

This list includes all publications of the Children's Bureau that are available for general distribution.

ADOPTIONS IN THE UNITED STATES AND ITS TERRITORIES, 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 39. 1957. 20 pp. Single copies available from the Children's Bureau without charge.

This report gives information from 31 States on adoption petitions filed in 1955. Figures are given for each State on the race of the children; their relation to the petitioners; their ages at the time the petition was filed, and at placement; the type of placement (by public or private agency, or independently—by relatives or others); whether the children were born in or out of wedlock; and, for children born in wedlock, whether or not both parents were living, and together. The report pays chief attention to petitions filed by persons not related to the child—more than half the total group.

NATIONAL STAY-IN-SCHOOL CAMPAIGN; handbook for communities. Department of Labor; and Department of Health, Education, and Welfare, Office of Education; in cooperation with Department of Defense. 1957. 23 pp. 15 cents.

This handbook asks parents, teachers, students, and all others concerned with the Nation's future to appeal to boys and girls of high-school age to stay in school and graduate. It gives suggestions on how to start a community stay-in-school drive; shows what various kinds of workers can do to help, such as school officials, editors, labor-union officials, businessmen, and social workers; and lists facts illustrating the importance of education.

Photo Credits

Frontispiece, Inwood House, New York, N. Y.

Page 189, University of Michigan News Service.

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NOVEMBER • DECEMBER 1957

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Health for Indians

Trends in Child Welfare

Hard-To-Reach Groups

Feeding and Cleft Palate

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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This mother and child inside a hogan on the Navaho reservation in Arizona are 2 of the 370,000 persons in 26 States and Alaska for whom health services are being made available through the Indian health program of the U. S. Public Health Service. (See p. 203.) Serving Eskimos and Aleuts as well as Indians, the program provides services through Public Health Service hospitals and clinics and through contracts with non-Federal hospitals and with private physicians and dentists.

house, only young children. The story had to be broadened for the woman's benefit. Repetitive examples, showing the fly as an enemy in a variety of situations, eventually resulted in an automatic association of flies with health problems.

The Public Health Service employs health educators and community health workers, many of whom are Indians, who can relate themselves closely to Indian groups. These people have learned by living among Indians what the tribes believe and practice. They use this information in helping Indians to understand, accept, and adapt the ideas which the health profession considers desirable.

In the clinic the wearing apparel of the mothers and children varies from traditional Indian garments made at home to ordinary types bought from mail-order catalogs or from local general stores. One lovely little girl proudly wears a fluffy, flowered nylon dress; nearby, a baby is unstrapped from a traditional cradleboard for examination and immunization.

Since this is a well-baby clinic, most of the babies appear to be well nourished and strong. Sick infants usually are taken to the Indian hospital clinics rather than to facilities of this type.

Not all of the clinics are as well situated as this particular one in the Pueblo village. On the vast Navaho reservation—which covers 25,000 square miles—clinics are held periodically at some 75 remote locations to serve isolated population groups. One clinic, for example, is held in a single-room storehouse beside a trader's home. Thirty miles from a highway, with only one nurse in attendance, its waiting room is the desert around the post. The nurse drives a jeep across the sand to get there.

An Indian health program doctor talks to an Apache mother after examining her child at the outpatient clinic of the Public Health Service hospital located at Whiteriver, Ariz.

A Far-Flung Program

The Public Health Service recognizes the importance of well-constructed and adequately equipped clinics and other facilities. Many are already in existence and others will soon be built. Shortly after assuming responsibility for the program, the Service conducted a survey to determine the most pressing needs in the physical plant and followed up with the development of plans to meet these needs. A number of new field health facilities, which will house clinics, and four new hospitals are in the planning stage.

Maternal and child-health services in the Indian health program—like its other services—must be provided in many types of environment and under a great variety of circumstances. This can be appreciated when one considers that the program operates in 26 States and Alaska; and that it serves such diverse ethnic groups as Eskimos, Aleuts, Indians who are integrated in the general population, and Indians who are relatively isolated on vast reservations.

The Indian health program itself is comparatively new to the Department of Health, Education, and Welfare, having been transferred to the Public Health Service from the Department of the Interior on July 1, 1955. However, at that time the Public Health Service already had had considerable experience with the program and insight into its peculiar problems by virtue of the fact that for more than 30 years before the transfer it had detailed medical personnel to the program.

The Public Health Service operates 56 Indian and Alaska Native hospitals, about 85 health centers and field health stations, and 14 boarding school infirmaries. It maintains contracts with about 160 non-Federal hospitals and with many private physicians and dentists to provide care for Indian and Alaska Native patients where there are no suitable federally owned facilities.

Field health services, such as the well-baby clinics, are available at more than 200 other localities. As

in the case of direct medical care, additional public-health services are obtained under contract from 32 State and local health departments and the Alaska Department of Health. An example of contractual services for Indians is afforded by arrangements to provide public-health-nursing services for the Choctaws. In this instance, the Public Health Service pays the salary of a public-health nurse who works under the supervision of the Mississippi State Board of Health. All of her nursing services are devoted to the Indians on the Choctaw reservation where she makes visits to their homes. She works closely with the nearby Indian hospital, referring Indians there when necessary, and providing followup care and instruction to former patients.

Many State and local governments are broadening the scope of their programs—particularly in maternal and child-health activities—to include the Indian residents living within their jurisdictions. However, local governmental agencies are not now in a position to assume much of the heavy costs of furnishing the wide range of services needed by the Indians who live on reservations.

Indian reservations and villages are located in areas vastly different from one another—the Everglades of Florida, the mesas and deserts of the Southwest, the Northwest plains, and the Puget Sound area. Alsaka natives occupy islands, coastal villages, mountainous areas, and the Arctic tundra.

Cultural Differences

There is a great variance in cultures of these widely scattered groups. Some Indians have lived in close proximity with the white culture, have intermarried freely, and have been educated to the same degree as the non-Indians. Other Indian groups—particularly those which have been exploited in the past—have attempted to isolate themselves from the dominant culture. These groups tend to resist attempts aimed at furthering their acculturation. No matter how well meant, some of the efforts to bring benefits of health services to these people are met with hostility.

Still other tribes willingly accept services which are offered to them once the health workers have learned to surmount cultural differences and adjust their methods to conform with some of the Indian traditions. One hospital experienced little success in getting Indian women to come there to have their babies delivered. It is part of a ritual among the women in that area to drink cedar tea after delivery. Cedar tea was not served at the hospital, and as a result, prospective mothers felt they could not use its services. Once cedar tea was provided for the new mothers, acceptance of service was assured.

The different environments and cultural characteristics of the various tribes complicate the task of providing health services suited to their needs. The Sioux of the Northern Plains wish to have their people die at home surrounded by the family. In contrast, the Navahos in the Southwest try to avoid having a tribal member die inside their homes because of deep-seated religious convictions. In giving medical care, health workers must adapt their approaches to gain the support of two such different cultures.

Many health problems of Indians are closely related to their economic situations. Most Indians on reservations live in substandard homes without sanitary facilities. Water, besides being extremely scarce, often is obtained from contaminated sources. Proper methods of handling refuse and controlling flies are not widely used. When one considers that the average Indian family has an income of less than $1,000 a year and lives in an overcrowded house with a limited water supply, it is surprising that even more major health problems do not exist.

Because of the dearth of water and poverty of the soil, vegetable gardens are almost unknown on the Navaho reservation. Dairy farms do not exist in the area, and in most Navaho communities no attempt is made to raise poultry. For generations the Navahos have roamed the reservation seeking food for their sheep, which in turn provided food and clothing for their families. Over the years, low incomes, lack of transportation facilities to trading posts and towns, reduction in the availability of wild foods, and the absence of facilities for food storage have resulted in the establishment of a limited dietary pattern, consisting chiefly of meat, bread, dried beans, and coffee, supplemented, where there is money enough, by canned tomatoes and in the summer by squash and melons.

Today high food costs and a growing preference for the white man's processed foods are resulting in an excessive consumption of fats and carbohydrates. Acculturation is not an unmixed blessing for these Indians.

An important part of the Indian health program is assisting Indians to plan better diets. The Public Health Service employs nutrition consultants who help the nurses of the clinic staffs. They are attempting to improve the dietary patterns of mothers and children within the framework of the tribal culture

and the limitations of the economy. Thus they must consider what low-cost foods are available, the lack of refrigeration or storage facilities, and the scarcity of water for use in food preparation.

To counteract the unfavorable environment in which the Indians live, the Public Health Service has developed a sanitation program which provides instruction in the proper methods of storing and handling water, insect control, and privy construction. Indian sanitarian aids, trained by the Service, return to their native home and villages with newly acquired knowledge and teach their people correct sanitary procedures.

Health Problems

The costs of providing medical care and preventive health services to Indians is greater than for the non-Indians who live nearby because of the isolation and poor transportation on the reservations, as well as the cultural barriers which must be overcome.

Recruitment and retention of personnel continue to be hampered by a shortage of satisfactory housing, despite the fact that many new housing units for Indian health personnel have been provided in the last 2 years. The professional isolation which is encountered in most of the Indian health staff assignments leads to a high turnover of staff.

Physicians and nurses who accept assignments in Public Health Service Indian hospitals find that often they are treating illnesses which are rarely or never seen in most hospitals in this country. These include trachoma, severe malnutrition, typhoid fever, tuberculous meningitis, and serious long-neglected deformities. The wide prevalence of congenital dislocation of the hip among certain groups of Indian children is in marked contrast to the rarity of poliomyelitis among the Indians. Epidemics of measles and whooping cough are devastating, and the high incidence of tuberculosis is a grave problem. In general, health conditions among American Indians are similar to those which prevailed among the rest of the population many years ago, when knowledge of sanitation, nutrition, hygiene, and curative measures was too limited to prevent undue illness and early loss of life.

A few statistics help to measure the contrast between the health of Indians who live on reservations and that of the population of the United States as a whole. The average age at time of death for Indians is 39, compared with 60 for the general population. This gross disparity in age at death is largely a reflection of the extremely high mortality rate among Indian children as compared to others.

The Indian and the general populations have about the same death rate per 1,000 live births during the first few days of life. After the first week, however, the Indian death rate begins to increase, and by the end of 11 months of life the Indian death rate is nearly six times greater than that for all races combined. The main causes of excessive Indian deaths in this age group are pneumonia and gastrointestinal diseases. These are diseases which have been brought under control for most of the population.

Diseases of pregnancy and complications of childbirth led to a death rate of 6.2 per 100,000 in the Indian population, compared with a rate of 1.5 per 100,000 for all races, in 1953. An appreciable number of births among the Navahos and Alaska Natives are attended not by a trained person but by a member of the family or a neighbor.

These statistics plus the high rates of sickness and handicap in preschool and school children indicate a widespread need for maternal and child-health services of good quality. It is clear that the health status of the next generation of Indians depends in large measure upon availability of these services today.

Coordinated Efforts

Improvement of maternal and child health in this population requires the coordinated effort of personnel in many fields of health. Public-health nurses, sanitarians, and community health workers join the hospital staffs in combating infant diarrhea by teaching better food handling, insect control, and encouraging early hospitalization. Although gastrointestinal disease is one of the major causes of deaths among Indian infants, it is becoming increasingly rare for a child to die who is brought to a hospital for treatment.

The medical officer in charge of the Public Health Service Indian hospital at Fort Defiance, Ariz., in a summary of infectious-diarrhea experience during 1956, reported only 1 death among the 161 infants and children admitted with diarrhea. The 1 death was a 4-month-old baby who had been born prematurely.

Preventive as well as curative services are needed to give Indian mothers and children the opportunity to attain and maintain optimum health. The importance of prenatal care is stressed, and pregnant women are urged to come to the hospitals and clinics for instruction.

Health services for the Indian mother and child include care of the mother during pregnancy and childbirth; health supervision of the infant and preschool child; treatment of the sick; and instruction of parents in health care of the family. The latter service points up the long-range objective of maternal and child-health activities—encouraging personal and community responsibility for providing and using health services.

About a year ago, for example, a plan was developed on the Pueblo Reservation which enabled Indian parents to take their own children to clinics and hospitals. Previously, a public-health nurse had been transporting handicapped children to facilities outside the reservations. Although the distances involved were sometimes as great as 300 miles, the parents evinced much interest in accompanying their children. Mothers and fathers who travel with their children obtain a clearer understanding of the way in which health services are provided. This understanding results in many parents agreeing to whatever remedial care is suggested and available for their children.

The plan for having parents transport their children has brought results far beyond expectations. Only 3 years ago, when an Indian child was sent home from a hospital wearing a cast, the parents promptly took it off. Much of the benefit from orthopedic surgery then was lost to the child, because removal of the cast caused displacement of the bone and prevented healing. Now, however, even when children are returned home in body casts their parents take good care of them.

In a recent monthly report, a public-health nurse serving the Indians describes the excellent care which one mother had given her little boy who was sent home in a cast after orthopedic surgery. The child was also on antituberculosis medication, and the mother gave streptomycin part of the time under the nurse's supervision. When the boy was returned to the hospital, his cast was still in good condition. Soon afterward it was removed, and the child was completely active in a short time.

Indian parents are beginning to change their attitudes toward handicapping conditions for the better as more children receive corrective surgery and consequently are able to learn to walk, run, or talk. They are becoming remarkably cooperative in bringing their children for early care to Public Health

On her way to make a postpartum visit to a Navaho woman, a public-health nurse approaches her patient's home—an adobe-capped, timber hogan. It is typical of the dwellings in the vast Navaho reservation of New Mexico and Arizona.

Service facilities or to State clinics for crippled children and also in requiring their children to undergo care and followup procedures. Previously, when a child was reluctant to leave home, parents did not insist. Now parents in increasing numbers say that they feel that their children in later years will hold them responsible if the remedial work is not done at the most favorable time.

The methods of conducting maternal and child-health activities are as varied as the services they give. Hospitals and other medical facilities receive guides and standards for maternal and child care. Specialists in pediatrics, employed by the Service on a consultative basis, recommend methods for improving services in obstetric, newborn, and pediatric units. To insure continuity of patient care, referral systems between hospitals and field health facilities have been developed.

Much has been accomplished in the last 2 years. But much more remains to be done before Indian mothers and their children enjoy the same chance for health as their non-Indian neighbors.

How a renewed emphasis on a long-held social-work conviction is leading to . . .

REDIRECTIONS IN CHILD WELFARE

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THE MOST fundamental redirection in child welfare in recent years stems from a growing appreciation of what is meant by the concept of "a family of his own for every child." It is a renewed emphasis on preserving the child's own home. However, as this concept has been the focus in planning for children since the earliest White House Conferences, the question might be raised as to whether it is, in fact, a redirection.

It seems to me, however, that the concept now has greater clarity and deeper meaning than it once had; that now and for long into the future it will have a profound effect upon everything we do in the field of child welfare. It forecasts in a very real sense a redirection in the total child-welfare field.

This concept is bringing new meaning to social services to children. It is challenging many child-welfare agencies' traditional emphasis on foster care. It is bringing about revolutionary changes in the field of adoption. It is helping to clarify the distinctive aspects of child-welfare work. It will, undoubtedly, affect future agency structure and organization. It will bring new efforts to coordinate services and a reemphasis on community planning. It will bring significant changes in child-welfare legislation. It will call for a reevaluation of the relative emphasis among the components of the community's investment in child welfare. It will bring more testing of new ideas, and a richer use of old methods. It will bring new demands for research in child welfare and a new look at staff training and development and at the task of identifying and encouraging community leaders.

How can such a simple concept, which has been a part of the child-welfare worker's thinking for so long, bring about such fundamental changes?

During its early years child-welfare work was rooted in foster care. It was oriented toward removal of children from their own homes. Communities reenforced this orientation because they liked what they saw—the rosier cheeks, the scrubbed bodies, the clean clothes. It took a long effort on the part of the children themselves, often through bizarre behavior, to make us realize what separation from their parents was doing to them, to show us the limitations in foster care, and to prove to us the irreplaceable value to the child of life in his own home.

Children need families of their own. They need someone to love them, to protect them, to give them security. Perhaps no one understands this more fully and more poignantly than child-welfare workers. They have had long experience in seeing the unhappy results of many foster-care placements.

Many things have happened that have forced child-welfare workers to take a critical look at placement. Some parents are now coming to our attention for

Based on a paper presented at the 1957 forum of the National Conference of Social Welfare.

service because as children they drifted along in foster care. Having had no real parenting themselves, they do not now know how to be good parents. We child-welfare workers have talked too long about working with own parents while children are in foster care. Experience has shown that failure as a parent is one of the truly great failures and that separation of parents and children often proves to be a long step toward permanent family disintegration. The great motive for parents to do better often goes out the window when the child goes out the door. We are challenged to increase our efforts and improve our skills in working with a child's own parents.

Parents of Their Own

Social agencies are realizing more clearly than ever before the hazards they face in attempting to provide continuity of care in foster-family homes for children who cannot be placed for adoption. Even so, it is difficult to provide a child with a continuous experience with the same foster parents, understanding of and capable of meeting his changing needs. Foster parents who are excellent for young children, for instance, may be unable to cope with adolescents. Too often children spend their lives in a succession of foster homes.

Through their behavior the children themselves are telling us what they need in foster care. They are telling us, in many different ways, that good physical care often means little to them if their emotional needs are not met, if they are not anchored to some element of security. They are telling us that they need many things of their own: their own family; their own neighborhood; their own school; their own friends; their own church. Two boys in Washington, whose home burned down and whose parents burned to death while they were at school, expressed this poignantly. Their first words after seeing the ruins of their home indicated: "We want to stay *here*, in *this* neighborhood, and go to *this* school." In their shattered world, they clung desperately to the only familiar things they had left.

Child-welfare workers are frequently amazed at what emotional blows children can survive if their families can hold together. We are growing steadily in our respect for the cohesive power of the family. We are realizing more and more that most parents, even those who may be failing their children, want to be good parents and that, with help, most of them have the capacity to change for the better.

In the early days we said that children should not be placed in foster care for economic reasons alone. Now we are saying that foster placement can rarely be an adequate answer to a child's need for a home and parents of his own.

This means that child-welfare agencies must assume greater responsibility for preventing family breakdown and for helping parents in their task of child rearing. Toward this end agencies are providing more and more services to children in their own homes. In the process they are learning how to help parents use their strengths for the benefit of the child. Much of this effort, particularly in the expanding public social services, must go into services to children who are neglected or abused by their parents. As society has become more complex family tensions have increased, and these tensions are reflected in the lives of children. More children are being referred to agencies for service because of abuse or neglect by their parents. Consequently, protective services are taking on greater significance in public child-welfare services.

If children of families under stress are to remain in their own homes, agencies must call on a variety of resources. This means they must develop certain services within their own structures and stimulate new or expanded services within other community agencies. Unfortunately, two services that can contribute much to preserving a child's own home have progressed but slowly in this country. One is homemaker service, which can safeguard, stabilize, and unify families. Today only 95 cities in 31 States, the District of Columbia, and Puerto Rico have even beginnings of this service.

Another means of keeping children in their own homes—day care of children whose mothers must work—is the "stepchild" of welfare services. The number of women going into the labor market has been increasing steadily for 20 years. The proportion of working women with children under 6 years of age is growing rapidly. Yet adequate day-care facilities are few and far between. States have tried to meet this need by strengthening their licensing programs, by developing standards for day care, and by providing training courses for day-care operators. Yet the hard core of the problem will not be met without the provision of new facilities such as foster-family day-care homes and day-care centers.

More and more children are being returned to their own homes from foster care. In one State with a long history of State wardship and the placement of many children in foster care, fewer children were

committed to the State welfare agency in 1955 than in 1936 despite a great growth in child population. In 1936 the children committed to the agency far outnumbered the children released from agency care. Now the number of children being dismissed each year is greater than the number of children committed.

Work with parents leading to the return of their children to their homes has been a major factor in this trend. There have been other important factors too, especially the aid-to-dependent-children program. In addition, smaller child-welfare caseloads have given workers more time to work out permanent plans for children who cannot return to their own parents. As a result, many more children are being adopted than in the past.

Trends in Adoption

This is all part of the trend which is placing renewed emphasis on the concept, "A family of his own for every child." If a child cannot live with his natural parents or with relatives, the only other really permanent solution is an adoptive placement. There is no problem in finding adoptive homes for white infants. Indeed, the demand for these is creating serious problems through independent placements of these children without essential safeguards in the study and selection of homes. Some of these placements come about as a result of the feeling, held by many people, that any well-meaning person can find a good home for a baby; of the lack of services to unmarried mothers; and of the profit that is sometimes made in such transactions. Nearly 25,000 babies and their mothers are involved in independent placements every year.

However, any child who is not Caucasian, in good physical condition, and an infant has a tough time when he needs adoption. But hopeful things are happening for him too. Social agencies are beginning to find that practically no child is unadoptable, and are even beginning to react against the new term "hard-to-place child." New efforts for these children, being undertaken in many places, are bringing results. Steps in a number of States toward the organization of an adoption resource exchange should spur such efforts on.

The adoption field is being greatly stimulated and expanded by the development of new services, particularly under public auspices, and by rapidly changing agency practices which make possible earlier placement of infants. Sounder criteria are available for assessing the capacity of would-be adoptive parents for parenthood, and greater skill in their use is being developed. The adoption team—the doctor, the lawyer, the social worker—is being used with greater clarity and meaning. But a real need still exists to discover great untapped potentials in this country for the adoption of certain types of children.

The organization and structure of agency services will be greatly affected by these redirections. The conviction is gradually growing that child-welfare agencies should be the source in every community to which children whose problems lie in the area of social relationships or social functioning can be referred or to which their parents can come for help. This calls not for specific and isolated services but for a broad range of services and facilities to be available to them after a careful diagnostic study at intake.

The needs of these children and their parents will be many and varied. They may change many times while services are being provided. They may call for the utilization of a variety of resources. Yet while they exist they will require a sustained and continuous service. Will the future, then, present a challenge to those agencies which offer only one type of service to children and their parents? Will we see an expansion of agencies which combine broad-gage child-welfare services under one roof? Much evidence points in this direction.

An interesting example was the recent merger of several child-welfare agencies in one community into one children's agency which offers counseling service, placement of children in all types of foster care, service to unmarried mothers, child guidance, and service to adoptive couples. This agency reports that centralized intake has enabled its workers to listen more fully to the client and his expression of need, thus making the agency more sensitive to what underlies a parent's behavior and attitudes, whether he comes for placement or for guidance. It reports that "the parent who, in desperation, comes requesting placement of his child, may now be helped to examine his efforts to become a more effective parent. It is now more possible for some parents to decide to maintain their children at home and to utilize our counseling service toward this purpose."[1]

State Legislation

Some of these newer concepts may soon begin to find their way into State child-welfare legislation. The Children's Bureau has attempted to incorporate some of them in a draft of principles and suggested

language for legislation on public child-welfare and youth services. The purpose of the legislation is "to promote, safeguard, and protect the social well-being and general welfare of children and youth in the State, through a comprehensive and coordinated program of public child-welfare and youth services." The program is defined as including the functions of the State welfare department in respect to: (1) the establishment and enforcement of standards for social services and facilities for children and youth; (2) the provision of such services to children, youth, and their parents and of care for children and youth needing it; (3) the promotion of coordination and cooperation among organizations, agencies, and citizen groups in community planning, organization, and development of services.

This is a great advance over early legislation which tagged children as dependent, neglected, or delinquent; which labeled the children of unmarried mothers as "bastards"; which in respect to interstate placement focused not on protecting children but on protecting the State from financial liability; which provided for the indenture of children as a method of child care.

Clearer Definitions

If we are to move forward in understanding the needs of children and their families, in providing the essential services and facilities they require, and in interpreting these programs to the community, we must define more precisely than ever before the specialized area of child welfare; we must determine its particular characteristics and the type of agency responsibility it involves.

To do this, we must understand the nature of children in all their formative stages of development. We must understand clearly what is adequate parental care and what is the special responsibility carried by society for children.

When parents cannot provide adequately for a child's needs part of their parental responsibilities may have to be assumed by a child-welfare agency. The responsibility assumed may range from a relatively simple duty to a formidable array of duties, such as arrangement for his food, clothing, and shelter, or the giving of consent for surgery, adoption, or marriage. These are serious responsibilities, indeed.

Involved also is the matter of guardianship. The concept is taking hold that behind every child should be an individual able to exercise effective guardianship responsibilities for him, whether that individual be his natural or adoptive parent or a person appointed by the court. This concept, if accepted, will help to safeguard the child's rights and provide him with someone who has a special interest in his well-being. When a legal guardian is appointed for a child but his care and custody are vested in an agency there must be a clear understanding of both the agency's and the guardian's responsibilities.

Community Planning

And now I come to my last redirection, namely, a redirection in community planning for child welfare. We have stressed the importance of preserving a child's own home. But we cannot pursue this goal in a vacuum. All parents need help from the community in some degree in order to bring up their children in health and happiness.

Many things are happening to our culture and in our society that affect this basic unit, the family. These are too numerous to describe fully, but the following seem most significant: the explosive growth of our population and its changing nature; the growing complexity of our society; the mobility of our population; and changes in urban and suburban development.

Today the two extremes of our population are increasing rapidly—the children and the aged. By 1965 we shall have more children than there were people in the country in 1895; the number of children under 18 years of age will then be about 70 million.[2] The size of our families is increasing. The tremendous geographical mobility of our population takes people not only across county and State lines but also from rural to urban and from urban to suburban living. Still another type of mobility is the movement of married women out of the home and into employment. The National Manpower Council states that a revolution in women's employment has occurred in the course of our present century.[3] The past decades have also brought unprecedented pressures and strains in our society, and many tensions have developed in family living.

These are not changes to be viewed with alarm. Rather, they present the challenge of a growing, healthy, expanding community. But we have to be prepared to pay for the social cost of the problems they bring and to meet them in creative ways.

What do these developments mean for child welfare? The obligation of child-welfare workers extends beyond the development and provision of social services to children and their families. It includes being concerned with the effects—for good or ill—that current scientific, social, and economic

conditions have upon family and child life and sharing this concern with others. The widening vistas of knowledge and understanding, the greater ease in communication make it increasingly apparent that none of us can live, work, or move forward alone. What only may have seemed to be the concern of a single profession, a single agency, or a single group must now involve several.

Community organization and planning, then, must be a vital part of all child-welfare programs. This calls for the use of much more orderly and responsible methods than in the past. The social-service staff of the Children's Bureau once proposed a rather simple definition: "Community organization for child welfare is a process which enables people to band together to achieve a particular objective for children."

This definition is based on the theory that for child welfare, at least, community organization functions best if it is integrated into the existing structure of services. To be effective, however, it must be a part of total program planning in an administratively created climate which is conducive to functioning. It should not be left to the chance of the worker's having a particular interest or flair in this direction. It should flow from the top down.

We see more and more evidence of concerted action for children. It may start around a particular problem, a gap in service, a public concern. It may stem from a variety of sources—an individual's initiative, a legislative committee, a special emphasis by a national agency, a doctor's interest in the problems of adoption, a parent seeking help for a mentally retarded child.

Social work has a body of knowledge and skill that is basic to community planning and therefore has a vital role to play in this development.

In some efforts in community planning for child welfare, the social-work profession will take the major role; in others it will join in cooperative action with other professions and fields of interest. Often its main role will be to help build strengths into other groups so that they can meet children's needs more effectively.

One interesting stimulus toward community planning comes from the United States Department of Agriculture's rural-development program, now in its third year. Its goal is improvement in the level of living in depressed agricultural areas. Its activities involve youth to a great extent, especially stressing employment opportunities, but its total interests are broad and varied. In one small rural county in the South the local committee pointed to a lack of adoption services and the need for more services to parents receiving public assistance as evidence that the local department of public welfare had a direct contribution to make to the rural development program. The committee also expressed the need for trained social-work personnel in the county. It established short-time and long-time goals for the county, based on material presented by each administrative agency.

Future Needs

The future calls for child-welfare services so complete in coverage that they can truly reach out to and serve all children and parents who need to be served regardless of whether they live on farms, in central cities, or in suburbia, regardless of their income, and regardless of what their particular problems may be at the moment.

This goal demands greatly expanded services and a broadened program. It means improved services at intake, carried out with improved diagnostic skills and increased efforts to allow children to remain in their own homes with their own parents. It calls for specialized foster care for children who must be removed from their own homes, not just in *any* institution or *any* foster home but in *the* specialized facility that will meet the particular child's special need at a particular time. It makes more conscious community planning mandatory. It requires more evaluation and research in the child-welfare field. But perhaps above all else it calls for workers with greater skills: in working with parents; in relating to children and in understanding their behavior; in helping adoptive parents function in their new role; in handling community pressures; in participating in community action.

This paper began with the simple concept, "a family of his own for every child." Perhaps we can search out new directions for child welfare in the future by repeatedly asking ourselves a simple question: "Is it well with the child?" For if it is "well with the child" the well-being of our communities and of our Nation, perhaps even of the world, can be assured.

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[3] Greenberg, Irving; Bookman, Alan: The value of a merger of children's services. Child Welfare, February 1957.

[2] Prediction based on Current Population Reports, Population Estimates, Series P. 25, No. 123. U. S. Department of Commerce, Bureau of the Census. October 20, 1955.

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How a family agency and a hospital cooperate in giving families . . .

HOMEMAKER SERVICE IN A MEDICAL SETTING

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NEWER DEVELOPMENTS in medical care have had a definite effect on both the supply and demand for homemaker service. Earlier return of the patients from the hospital to home, changes in outpatient facilities, advances in medical home-care services, and a trend toward caring for the dependent aged and chronically ill in their own homes have increased the kinds of situations where homemaker service is required. In many instances plans for care and treatment of a patient cannot be carried out unless such service is available to him. The problem of obtaining homemaker service in adequate amount and on time can create serious bottlenecks in the medical or other treatment process.

In recognition of the serious difficulties such bottlenecks can cause, the Jewish Family Service in New York has for the past 3 years been providing homemaker service to cases carried by the social service departments of three New York hospitals and a rehabilitation agency—the Beth Israel, Hillside, and Mount Sinai Hospitals and the Altro Health and Rehabilitation Service.

Out of a large body of experience in the provision of homemaker service, the Jewish Family Service has developed specific casework concepts, based on the generics in family-focused treatment, which are incorporated in a set of established policies covering eligibility, homemaker responsibility, and family participation. The agency has also built up a solid base of technique and skill in the selection, training, and supervision of homemaker staff, a specialized aspect of administration based on experiences distinct from those involving other types of agency personnel. The homemaker service arrangements with the four medical agencies were founded in an effort to broaden the application of these family-oriented concepts and of the experience-sharpened administrative skills.

The Plan

The kind of cooperative program worked out with the Mount Sinai Hospital is typical of the arrangements made also with the three other agencies.

In examining its experiences with referrals from the Mount Sinai Hospital Social Service Department for homemaker service, the Jewish Family Service concluded that cases where homemaker service is part of the medical-social treatment are of three types:

1. The case in which the main problem is medical and the hospital's concern is with the plan and treatment for medical care, the need for a homemaker arising from the patient's medical requirement.
2. The case in which the medical-social problems extending from the ailing person's needs include family care to enable the family and the patient to achieve optimal functioning.
3. The case in which there are difficulties in family living that can be more suitably dealt with by an agency other than the institution associated with illness.

As we looked at some of the cases in which the hospital and the family agency's homemaker service were both involved, we saw duplication of effort in a group of cases in which social workers from the hospital social-service department and the family agency's homemaker service were working with the same family, to which a homemaker had been sent because of the patient's medical needs. This naturally created confusion for the client and the necessity for considerable interchange between the workers of the two agencies.

Therefore Jewish Family Service decided to provide the service directly through the medical setting when the use of a homemaker was vital in carrying out the medical-social treatment plan for the patient and his family. This would make it possible for the worker in the hospital to coordinate all the treatment facilities needed by a family, directly providing the social-casework services related to its members' practical and psychological needs as these flowed from the medical-treatment plan. This type of case would be considered a Mount Sinai Hospital homemaker service case, with the family agency having no direct contact with the family. At the same time, the hospital's social-service department would refer other types of cases to the family agency which the two agencies would carry on a cooperative basis in the customary manner.

The arrangement left a great deal of room for decisions to be based on an individual case evaluation as to the most appropriate method of referral and application of service. It also allowed for referrals to flow from the family agency to the hospital's social-service department when treatment and use of homemaker service within the medical setting seemed advisable.

A Case Story

The X case is typical of the kind that has been carried directly by the Mount Sinai Hospital social-service department.

Mrs. X, the patient, was a 28-year-old mother of 3 children—a 4-year-old son and 15-month-old twins. Mr. X, a laboratory assistant who earned $90 a week, was attending college at night as a means of increasing his earning potential.

Mrs. X, a pretty, vivacious, young woman, had had diabetes for 22 years, with periodic attacks of acute illness. Through the years, she had been hospitalized six times at Mount Sinai Hospital—the last two in connection with pregnancies. Although the babies were born healthy, Mrs. X suffered with diabetic complications during both of her pregnancies.

During her second pregnancy, rheumatoid arthritis had set in, causing deformities in her hands and limiting their use. But even more serious than the chronic nature of the arthritis was the progressiveness of her diabetes. Medical authorities estimate that in many cases of diabetes symptoms of physical deterioration and vascular change can result from unregulated conditions. Only if Mrs. X took proper care of herself would she be able to forestall an unhappy prognosis in her own case.

Two years ago Mrs. X began to suffer frequent diabetic shock and increased diabetic infection, which she could no longer regulate with insulin and which interfered with her ability to meet the many needs of her family and household. She attributed this flareup to the fact that her children were requiring more attention from her than before because the twins were now able to walk. She felt physically unable to give them the constant supervision they required and still carry on the rest of her homemaking responsibilities. She was almost paralyzed by the fear that she would suddenly drop one of the babies or in some way accidentally hurt them during one of her shock episodes.

The clinic doctors were equally concerned about her. They felt that she would soon have to be hospitalized if her condition were not alleviated. They referred her to the hospital's social-service department with the recommendation that the social worker find some way of lessening the pressures to which she was exposed. They had observed that periods of tension significantly contributed to her inability to ward off shocks.

Before a suitable treatment plan could be made, the social worker had to determine what the factors were that were producing strain and exhaustion. Mrs. X's intelligence and readiness to participate facilitated these efforts.

At the outset, several plans were under consideration: convalescent care for Mrs. X; temporary placement of the children; or homemaker assistance in the home. The caseworker tested these possibilities against the facts that had emerged in the initial diagnostic interviews. Mrs. X had emphasized the physical stresses of the overwhelming amount of work confronting her since the advent of the twins. As they grew older she had begun to feel panicky lest she was not fulfilling their needs; and her sense of frustration had led to increasing irritability, shortness of temper, impatience, enormous demands on herself, and extreme unhappiness. She reacted to

the situation by greater self-sacrifice. Often she stayed up late at night to complete her chores of cooking, washing, mending, polishing shoes. Inevitably the few hours of sleep she did get would be interrupted by shocks. Obviously, she was not heeding any of the limitations set by her diabetic condition.

Mrs. X was unable to arrange for any assistance in the home. Domestic help was too expensive, and she felt that babysitters were unreliable and ineffectual. She had pestered her relatives to help her to the point that they had become antagonistic. Her husband, busy with his night classes in addition to his job, could give only a little time to household chores.

Obviously the increased size of the family had created new responsibilities for Mrs. X that had taxed her physical endurance. But even more essential to the caseworker's evaluation than this fact were the indications brought out in the initial interviews that personality factors contributed heavily to her present state of chaos. She was an anxiety-ridden, compulsive person with deep feelings of inadequacy, unworthiness, and guilt. In spite of her feeling of being overwhelmed by work, she continued to carry out a number of self-exacting practices. For example, in feeding the babies, she prepared the food herself, since she did not believe in using store-bought baby foods. She would thoroughly bathe the babies after each soiling. She took the babies outdoors for at least 5 hours a day. She not only dressed the twins identically, but would change the clothing of both if one spilled something on his suit. Her compulsive ways were also expressed in other areas.

Mrs. X's women relatives had reinforced the intensity of her self-demands. Her mother, a very dominating person, had relieved her of duties in the home when she was young and had relegated these responsibilities to her two older sisters, who had shown their resentment by reproaches and criticism. Consequently, she had grown up feeling that her sisters were superior to her in their personal and home-management abilities. Later, when she had married, her mother-in-law turned out to be a very conscientious, hard-working person who kept her home immaculately clean. By comparison, Mrs. X considered herself a failure.

A central factor in this competition and self-punishment was Mrs. X's attitude toward her diabetes. Her longtime effort to deny the existence of the illness had caused her progressively to put up a front. She had built up a set of compensatory and defensive ways to cover up the deep sense of inferiority and inadequacy the illness gave her. For example, she had never divulged to anyone outside of her family the fact that she was diabetic. She had even managed to keep it from her husband before their marriage. Much of this unhealthy attitude had been instilled by her maternal grandmother, a diabetic herself.

Mrs. X's husband also reinforced her need to keep up appearances. He was a devoted and intelligent husband and father, and particularly helpful during her attacks of diabetic shock. But he too suffered from a sense of inadequacy. Despite their moderate income, he went along with his wife's stress on material possessions. He shared her high standards for flawless appearance and a spotless home. In addition, his efforts to fulfill strong intellectual drives produced conflict, since such pursuits limited the amount of help he could give in the home.

The Treatment

The treatment plan for Mrs. X had to be based on a consideration of all of these interrelated factors—the requirements of running the household, the medical-physical restrictions placed on Mrs. X, her underlying personality characteristics, and the limitations of the family members. Although Mrs. X first tended to emphasize the external pressures, she was able to benefit from the exploratory interviews with the caseworker to the point where she could direct her attention to the feelings of strain and frustration which she admitted she had long had. Although her appeal for help had originated as a request for household assistance, she enlarged it to include help with emotional problems.

In discussing the situation with Mrs. X the caseworker supported her rejection of temporary placement for the children or convalescent care away from home for herself. Either plan would separate her from her family, create new tensions and aggravate her sense of deficiency. Mrs. X was far more enthusiastic about the proposal that she use the services of a homemaker in combination with casework help.

This plan seemed to offer multiple benefits. The family would be kept intact; immediate relief from household duties would be provided, Mrs. X would have better medical care; and there was some likelihood that she could be helped with her problems in personality adjustment, in home organization and financial management. Improved budgeting might eventually provide means for the family to secure private domestic help. It was hoped that success through this total approach would prevent the re-

currence of excessive stress. Mrs. X's physician favored the plan because of the reduction it would bring in physical and emotional pressure on the patient.

The caseworker saw the homemaker as offering Mrs. X more than household help. Her presence in the home would enable Mrs. X to keep regular casework appointments and might serve as an example of how home responsibilities can be met in a more realistic way.

The hospital's social-service department turned to the Jewish Family Service Homemaker Service for assignment of a homemaker. At a conference between the two agencies, it was agreed that the hospital's caseworker would assume treatment responsibility for the X case. Some of the problems which might arise in a situation in which both homemaker and patient participate in the homemaking responsibilities were also discussed.

The homemaker, assigned to the X family to work full time, 5 days a week, was well chosen for this placement. She was a middle-aged woman whose personality was in sharp contrast to that of Mrs. X—a circumstance the caseworker eventually used to advantage in helping Mrs. X to achieve more understanding of herself.

Mrs. X was aggressive, compulsive, disorganized, and excitable—never allowing herself a moment's rest. The homemaker was calm, patient, passive, and well organized. She was able to select first things first, and to take an occasional break to maintain a balance between work and rest. By Mrs. X's standards, the homemaker was much too slow; and according to the homemaker, Mrs. X was inefficiently fast.

For any homemaker this would be a particularly difficult assignment. At first Mrs. X tended to use the homemaker to get more work done. In order to help the homemaker maintain her role in the treatment plan, the caseworker arranged regular conferences. In fact the caseworker functioned as a medium through which the tensions created for both Mrs. X and the homemaker by their daily association could be dissipated and the positives in their relationship could be reinforced through support of their efforts to work with one another. The caseworker tried to convey the idea to both Mrs. X and the homemaker that all three—the caseworker, the homemaker, and Mrs. X—were working for the well-being of Mrs. X and her family, and that each had a separate role to play. This approach helped Mrs. X to reduce her rivalry feelings toward the homemaker and to be less critical of her.

This homemaker (right) from a North Carolina county welfare department is helping the oldest daughter of a family of eleven children to dress some of the toddlers while the mother is in a tuberculosis hospital and the father away at work.

One of the problems that arose was Mrs. X's reaction to the homemaker's passivity. She felt that the homemaker did not like her, and complained that the homemaker did not show much enthusiasm for anything she did or said. She felt frustrated by the homemaker's quiet and reserved nature. Mrs. X was apparently trying to relate to the homemaker as to a mother and was expecting the demonstrative signs of approval, acceptance, and affection which she thought a good mother should give. Recognizing this, the caseworker helped her to develop a more realistic, less dependent relationship by reassuring her of her acceptability to the homemaker, by interpreting the difference in their personalities and by helping Mrs. X to achieve some degree of insight into what she expected of the relationship. As a result of Mrs. X's growing self-perception and increasing self-confidence, she developed a better acceptance of the homemaker.

The homemaker also became able to work better with Mrs. X. She responded well to the caseworker's support of her own sense of proportion in home management and organization. The caseworker also helped her to recognize some of the problems Mrs. X created for herself by her excesses in behavior, her self-neglect, and the high demands she made of herself and others.

One of the first indications of Mrs. X's improvement was an apparent ability to slow down a little—to sit down for lunch and to put off certain tasks

which ordinarily she would have had to complete at a given time. This achievement came after discussions of her health needs in relation to being a good wife and mother and of her testing out in the home her modified concepts of what her role should be. As Mrs. X began to change her daily living, she was helped by the homemaker's setting an example for her for periodic rest in a day of work.

Mrs. X's complaints to the caseworker about the homemaker's slowness set off discussions in which Mrs. X became aware that she could not accept slowness in herself. Eventually she was able to reevaluate her own standards of performance by using that of the homemaker as a measurement of normal performance. Through the interviews, Mrs. X began to regard her own quickness in some areas as talents which she had always underestimated and began to achieve a greater sense of accomplishment. She also began to recognize what little consideration she had been giving to her physical restrictions and to her emotional welfare.

As Mrs. X's anxieties abated, the focus of the casework interviews shifted more to her personal problems.

Although the casework contacts centered on Mrs. X, her husband was included in the scope of the treatment. A more mature person than his wife, in spite of some personality difficulties, he was able through observing her progress to recognize some of his own problems.

Because it was an important dynamic in this situation, the homemaker was encouraged to express openly her warm feeling for Mrs. X. The caseworker effected a relationship that helped the homemaker's own natural approach serve as a learning experience for the patient.

The homemaker remained in the home about 8 months and in this time Mrs. X made slow but definite improvement. Her diabetic control was restored and everyone, including the doctors, was gratified by her medical and personal progress.

In this case the long-range goal of reorganizing the family's way of living related to the serious illness of the mother. Mrs. X's illness, her relationship with her family and her ability to function were so interrelated, that it was logical that all the different services she required be integrated within the hospital caseworker's role.

In another case the hospital's social-service department used the family agency's homemaker service to help sustain the gains in psychiatric treatment for a young woman after childbirth. Here all the factors in the patient's and her family's need for help were correlated by the medical social worker who began planning for the homemaker service while the woman was attending the prenatal clinic. This service was provided not only during the woman's confinement at the hospital but also during the period of adjustment to the new baby at home. Here too the direct relationship between the caseworker and the homemaker service was essential for helping the family to use the service as a step toward finding a way of managing on their own insofar as possible.

Procedures

In developing suitable procedures for integrating homemaker service in the medical-casework setting, the administrators of the hospital's social-service department and of the family agency's homemaker service held several meetings with the social-service staff of the hospital to explain in detail the purpose and use of homemaker service, and with the family agency's staff to explain the special needs and structures of the hospital's social-service department. Forms and procedures were devised for filing requests, assigning homemakers, and providing for contacts between workers and homemakers on assignment.

When a social worker in the hospital has a case requiring homemaker service, she discusses this need with her supervisor who presents it to the administrator of the family agency's homemaker service. This may be through a telephone conversation followed by a further conference by telephone or in person. The homemaker is assigned by the family agency after a preassignment conference between the homemaker and the hospital caseworker at the hospital or in the family agency's office in instances in which some unusual factors in the situation require handling in the presence of the homemaker's supervisor. The homemaker knows that the family agency is still her employer expecting the same work standards of her although the supervising caseworker is from another agency.

Not all the procedures and policies in use in the Jewish Family Service have been completely applicable to this program. For instance, the agency's fee scale is used with the clients who receive homemaker services, thus raising the question of whether the fee for this service can be tied in with payment for an all-inclusive medical care plan. Although these medical agencies use the same basic budgetary standard applied by the family agency, separate payment for the homemaker is apt to result in partializa-

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tion of the service. Perhaps further experience will help to develop a policy more realistically related to a family's overall financial responsibility for medical, casework, and homemaker services.

The Values

To date, a total of 60 families have been served by the 4 medical agencies which have been working with the Jewish Family Service in this way. These 60 families did not need to go to 2 different agencies to get the services they required. The simultaneous intake for medical and homemaker service saved them not only time and effort but also an immeasurable amount of emotional energy. Furthermore, the treatment could be sustained by the caseworker who had direct contact with the medical and nursing staffs, therapists, and others involved in the comprehensive plan for care. She could correlate these findings and recommendations more directly in reaching diagnostic understanding and in planning toward the goal of optimum family-patient functioning.

We have noticed that when the hospital's medical-social worker carries full casework responsibility in a situation, she can, on a continuing basis, determine how the family is using the homemaker service. She is then better able to see when homemaker help is no longer necessary or when a shift to use of other types of household help may be desirable. The goal of greater and earlier self-management can thus more readily be achieved.

An important aspect of this integrated plan is that it has been possible without any increase in cost or expansion of service. While we recognize the overwhelming need for expansion of homemaker services, we feel the program represents an important step in the more efficient use of what is available. The specialized knowledge, experience, and administrative machinery of the homemaker service are applied to fit into the structure of the medical setting with a minimal increase of staff responsibility.

Other values cannot be measured as objectively. They are to be found in the attitudes of the professional staffs of the medical and family agencies toward the services each provides. Each has had an opportunity to understand the other's role much better. In seeking a homemaker service, referring agencies are often conditioned by the impression that the service is not available to meet immediate need, an attitude which can increase the wide gap in making services available to families in relation to their treatment needs. At the same time, the agency providing the homemaker service often feels blocked in its efforts to take into account sudden hospital admission and discharge in planning its services.

Since the beginning of the relationship between the Jewish Family Service and the four agencies times of need have arisen when, because all homemakers are assigned, requests cannot be immediately met. Experience has shown, however, that the closer understanding between the two agencies frees the caseworker's ability to react with practical plans for helping a family plan interim care. This type of reaction has also been apparent in the family-agency staff in respect to the limitations of medical treatment facilities. In other words, as we have developed more knowledge of each other's function, we have been making better use of our own services.

We feel too that out of our combined experience we are learning and finding out together how to apply basic generic and specific methods in treatment, when illness is the underlying problem. We also feel that we are making a practical contribution toward helping some families who have problems of a specific nature to get a needed service from within the setting where their treatment is focused.

. . . as you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt the cure the body without the soul, . . . for the part can never be well unless the whole is well.

Plato in Charmides

THE NATURE OF HARD-TO-REACH GROUPS

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The rise in delinquency over the past decade has stimulated increased efforts to find ways of transforming the attitudes and energies of "hard-to-reach youth"—those groups of young people of deprived backgrounds who scorn the usual recreational or "character building" facilities in favor of making their own excitement, too often in a destructive manner. The most frequent device used in these efforts is the "detached worker" or "street-club worker," a groupworker sent out by a social agency to meet these young people on their own ground—the street corner.

Such workers have had to grope their way in applying methods learned primarily for working with groups who have asked for service to those who eye it with distrust. But their recorded experiences are growing into a body of material offering possibilities for the development of a systematic methodology for reaching hard-to-reach groups.

A framework for the analysis and understanding of such groups in order to work with them is suggested in the accompanying article. It grew out of the author's review of records submitted by the attendants of a conference on youth groups in conflict held in Washington last spring under the auspices of the Children's Bureau, the National Association of Social Workers, the National Social Welfare Assembly, and the United Community Funds and Councils of America.

AS APPROACHES TO WORK with hard-to-reach youth groups are developed, there is increased need for a framework within which such groups can be understood and classified. Such a framework would be helpful in identifying the range of hard-to-reach groups needing services, in classifying these groups according to the kinds of needs they present, and in designing patterns of agency service which are differentially adapted to the various kinds of groups identified.

The need for such a framework arises from the fact that we do not now know or reach all the groups within the delinquent subculture which could use services. However, it is clear that in order to design comprehensive community plans for this segment of our youth we need to know what groups we might expect to find in the delinquent subculture of any one community and the various kinds of program which should be provided if we are to achieve coverage of service.

The reports from projects now operating with hard-to-reach groups in several areas in the United States reveal that such efforts are focused on different kinds of groups and provide different sorts of service designs. Although it is clear that these reports do not cover all the kinds of hard-to-reach groups to whom services might be offered, examination of four of them indicates some of the variety of types of groups now being reached and the patterns of service which have proved successful with them.

In one project a number of previously unrelated friendship cliques which had formed outside the project center were coalesced around a common interest identified by the worker. In the activities associated with this common interest this collection of cliques gradually became a group.

In another, a neighborhood play group of long standing which was beginning to annoy the neighbors found, with the help of the worker, a place in which to meet and developed a program of activities.

In a third, a broad community and interagency plan of action made it possible for the recreation center to maintain within its general program individuals and subgroups who had been disrupting the activities of a neighborhood recreation center to the point where their expulsion had seemed inevitable.

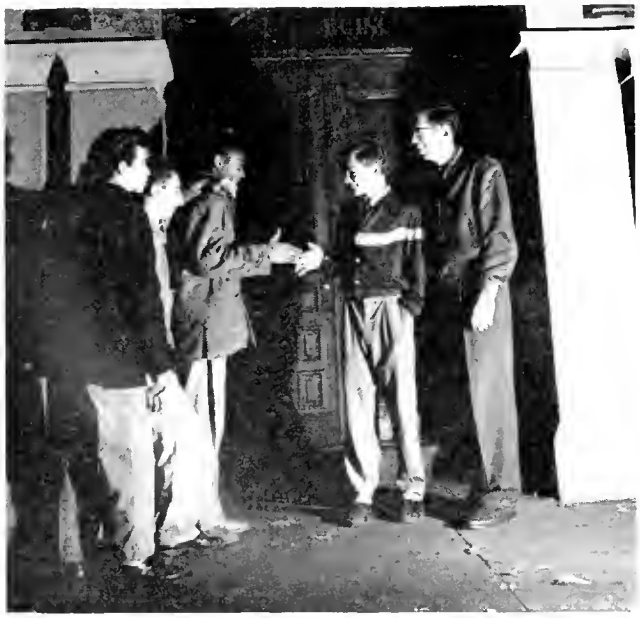
In a fourth, highly organized gangs, both self-identified and police-identified as delinquent, were served by a detached worker, who focused both on intergang relationships and on the needs of individuals within the group.

These brief descriptions show a variety of hard-to-reach groups which were found to need and be accessible to services as well as a variety of designs of service found to be useful in bringing about constructive changes within them.

The groups described have certain common denominators: They are regarded by the community as troublesome and possibly dangerous; and they are hard to reach within the usual neighborhood center program, requiring a "reaching out," and some sort of special effort to make them accessible to service.

The groups also show important differences. These lie in their stages of organization, degree of self-identification as delinquents, and readiness to attack society. Some seem to require more drastic adaptations of usual groupwork practice than others.

A street-club worker (right) poses in front of a New York police station with some boys who are pretending that they are members of rival gangs agreeing to call off a "rumble."



In order to classify hard-to-reach groups we need to locate the dimensions of group life which appear in every group and which vary from group to group within the identifiable range. Each dimension should tell something significant about the nature of the group life as an indicator of the group's stage of development and its needs.

What are the kinds of information which seem to reveal most about these groups, their needs, and their potentialities for using service?

I want to propose six dimensions which seem to me significant, or most predictive in diagnosing particular groups and in developing a useful classification of groups. In relation to each dimension I will suggest certain possible meanings which it may have for the action of the groupworker and the design of the service. While these proposed dimensions need testing against the facts of group life in specific communities, they appear in most of the reports of hard-to-reach groups collected up to this time.

Individuals in Groups

First, we should be clear about the kinds of individuals in the group membership. This dimension refers especially to the motivations of the individual members for participating in the group.

Recorded descriptions of young persons belonging to hard-to-reach groups seem to indicate that almost every individual within them is socially and personally handicapped, according to definitions of mental and social health. This picture of general deprivation is useful in a general way in determining what should be done with such groups in that it suggests that work with any such group must begin with simple processes and goals. The worker may have to teach these individuals and groups many skills in group participation which are taken for granted by young people who have had more advantages.

However, the social deprivation of the individual group members is so general within these hard-to-reach groups that it is not the predictive factor which differentiates among them. The recorded descriptions reveal three kinds of individuals whose proportional representation in a group seems to make a great deal of difference as to what the groupworker can and should try to do.

For instance, the groupworker may be dealing with a group in which most of the members participate for the satisfactions of fun, fellowship, and status, and because it is the peer group most available to them. This type of motivation is frequently found among members of hard-to-reach groups because

their families have not been able to give them a "home base" which satisfies the need to belong. By the same token youngsters deprived in this way may be more familiar than their more advantaged counterparts with using peer groups for emotional satisfactions.

If, on the other hand, a large number of the group members identify themselves as delinquents, whose hands are against the adult world and who seek to use the group as a tool for fulfilling their hostile and aggressive drives, then the worker has quite a different kind of group to deal with. He has still another kind if the group contains a sizable portion of severely damaged personalities who have little ability to move into more advanced social activity and who may move instead in the direction of a more isolated and withdrawn adjustment, such as the habitual use of narcotics.

Detached workers' records reveal that many hard-to-reach groups contain some of all three of these kinds of individuals. Such records also show that once a group begins to move into more socially acceptable activities requiring more advanced group skills the self-identified delinquents and the disintegrated inadequate individuals are likely either to drop out of the group of their own accord or be expelled from it by the process of group discipline. This fact may mean that we should think of the direct approach to groups as an efficient tool for serving individuals who have joined groups because of normal desires for fun and status, while various other ways may have to be devised for reaching and influencing young persons who are strongly self-identified as delinquents or who are too socially inadequate to participate in normally functioning groups.

Another dimension of predictive value can be found in the histories of individual group members.

The records of hard-to-reach groups indicate that all the individuals involved have suffered many sorts of social and personal trauma. They come from families who have been difficulty-prone, whose marginal position in society has turned every ill into a catastrophe. This fact certainly calls for mobilization of all sorts of basic services for the individuals in hard-to-reach groups. But, being general, it is not the key factor in the past of the group members which can differentiate what to expect from a group and what to do with it.

One aspect of the group members' past that may well be significant for such differentiation, however, is the proportion in the group who have a history of correctional experience. Correctional experience means more than brushes with the police; it involves being on probation or committed to a correctional institution.

I would expect to find among group members who have had such experience a certain kind of expectation of group patterns and a need to use the group in certain ways which are significantly different from the ways the group is used by the members without correctional experience. Those who have had correctional experience have through that experience been assigned a degraded status within the normal community. This fact will have affected their sense of who they are and where they belong vis a-vis the rest of the community. It is also apt to have intensified their need for a group which will give them status because of their delinquency. Moreover, many of them will have already experienced an acculturation to the kind of antiadult group life which develops in the population of an institution for delinquents. Such acculturation will affect their ways of operating in groups in the free community and may have much to do with their inability or reluctance to deal cooperatively with adults.

This does not necessarily mean that the more the group members have had correctional experience the more remote the worker must be from identification with the community's representatives of law and order. What it does mean is that the worker's awareness of the fact that individuals in his group have had correctional experience can help him understand certain of the expectations with which they participate in the group. Furthermore, it might be well for the worker who deals with a group having many members with correctional experience to find ways of bringing them into positive, reeducative experiences with the representatives of law enforcement and corrections.

Values and Structure

The degree of orientation to delinquency in the group's value system is a particularly important dimension of group life to examine in differentiating among the kinds of hard-to-reach groups.

In other words, to what degree has a given group adopted as a base for action the negative value system of the delinquent subculture? For instance, one group may accept delinquent behavior by its members or by cliques of its members and occasionally may as a whole group enter into socially intolerable activity. But this pattern is quite different from that of the group in which the prestige structure is

oriented toward delinquent actions, with the greater the danger and destructiveness of the act the higher the prestige.

It is easy to think of the delinquent subculture as somewhat homogeneous. But I am sure that among these hard-to-reach groups there are wide variations in the degree of allegiance given to the inverse values of delinquency. While all the young people within or close to the delinquent subculture are accessible and vulnerable to the subculture's negative value system, there are significant differences between individuals and groups who are annoying in order to have fun and who do not care whether the community disapproves of their ways of having fun; and those who are deliberately negative in their value system and who have substituted the "kicks" derived from attacking the community for the ability to enjoy normal fun. More information is needed from persons working with such groups about the various ways they give loyalty to and express the value system of the delinquent subculture so that we can identify in a meaningful way the different degrees of group orientation toward delinquency.

The nature of the group's organization is another dimension of group life which has already been recognized by students of this field as an important key to group classification. For instance, Peter Scott, who surveyed the literature on delinquent groups in a recent article, "Gangs and Delinquent Groups in London,"[1] proposes that the degree of group organization may well be the most important factor for such a classification. He identifies several kinds of groups: (1) street groups of adolescents who come together to satisfy their need for association with their peers and who as a group may never become delinquent; (2) casual and fleeting associations of individuals for delinquent purposes; (3) strong friendship groups for whom delinquent activity is only an occasional aspect of a long history of association; (4) loose collections of antisocial individuals who are not capable of group cohesiveness, but who are careless of the consequences of their activities and are apt to be delinquent; and (5) organized gangs with defined leadership and all the accouterments of group identity—a hangout, a name, and a clear power structure. Scott goes on to say that, in England at least and perhaps everywhere, the highly organized gang is a less frequent phenomenon than the amount that has been written about it would tend to imply.

Clarity about the nature of internal group organization is a prerequisite to effective work with any specific group. It may well be that patterns of work with the genuine gang are contraindicated for most of the groups needing service. The community service must beware of imposing on youth groups a form of gang organization by attending only to delinquent groups that are so organized. Designing service for all delinquent groups as though they were all well controlled, highly organized gangs may encourage groups of young people to strive for prestige by fulfilling society's expectations of them. It may be that some such "gangs" actually use the gang structure as a way of dealing with the adult world while carrying out many of their group activities within a much looser and more informal structure. At any rate, it is clear that the nature of group organization should be documented much more fully than it is at present so that stereotyping may be replaced by analysis.

This street-club worker (second from right) relaxing with a group of music lovers, was attracted to the jukebox by the knowledge that such a magnet might serve as an opening wedge for getting to know the boys of the neighborhood.

Two questions about the organization of hard-to-reach groups can be suggested for further examination. One, with two parts, arises from the experience of probation officers who frequently observe among delinquents a loose, temporary form of group association which is intensified by delinquent experience. It is: How prevalent are such group associations and how can they be served?

Very often a few individuals out of a number of persons who associate casually with each other will be caught in the contagion of an idea proposed by 1

or 2 of them, commit a delinquent act and be brought to court together. For a period this common experience binds these persons in an intense group relationship. Later on, 2 or 3 of these same persons are brought into court on another offense but the other associated offenders are found to be different from those in the first group. Thus the probation officer often gets the impression that the temporary, fluid, loosely organized group associations which have coalesced around particular delinquent experiences are even more frequent among delinquents than are groups with longer histories of association and continuity of group existence. If such groups are common in the hard-to-reach segment of our youth, perhaps there are ways of reaching them which would use the group itself to move the individuals toward more acceptable attitudes and behavior.

The second question is: How much change in organization and leadership must a highly organized delinquent group undergo to enable it to move toward positive, democratic experiences for the individual members? Experience in institutions has shown that delinquent groups can be used in cooperation with institutional staff to preserve order, but the impact of such use of the group on individual members remains autocratic, intensifying antisocial attitudes rather than modifying them. Persons who work with such groups must ask themselves searching questions about how far the autocratic group structure of the gang must be changed if the social experiences of the individual members are to be constructive. In other words, can the gang remain a gang if the group worker's goals of more constructive orientation are to be achieved? Will modification toward more socially approved group experiences involve the entire membership or will some members be selectively dropped in the process? And what can be done to help those individuals who cannot move with the group toward more democratic participation in socially acceptable activities?

The Group and the Community

One of the most predictive dimensions of group life in the delinquent subculture might well be found in the group's perception of its community. Although group workers usually note the nature of a group's relationships with the community, they perhaps do so in far too general terms.

Although often we think of the community as a unified, solid block of reality, the same for every individual, it is actually a different reality for each of its components. The community is a shifting complex of social groups and organizations standing in definable relationships to one another and looking very different to the delinquent group than to the social agency and the social workers. The delinquent group's view of the nature of the community is determined by the group's perception of those segments of the community which touch in some way on the group's own goals—some by actively frustrating them, some by providing help and some by remaining neutral.[2]

Observations of delinquent groups indicate that the delinquent tends to perceive adult groups in the community in relation to his own group as belonging to one of three categories:

1. There are those associations which are the adult form of his youth group and for which his peer associations are preparing him. These tend to be, in the city areas where many of the hard-to-reach groups are found, the political club; the sports club with its interest in gambling; and the organized criminal gang. Such adult groups offer not only models for youth-group activity, but anticipation of ultimate membership in them and patterns for future action on becoming adult. In pursuit of their own interests such adult associations may involve youth groups or their members in undesirable or illegal activities, although participation in some of the adult groupings may sometimes be constructive. However, in order to understand any given youth group we need to ask the following questions: What are its relationships to such adult groups? What do these relationships mean for the maturing social experiences thus provided the youth group and its members? What can be done to make these relationships influential in a socially acceptable direction?

2. Another adult segment of the community is perceived by a delinquent youth group as related to it an actively hostile manner. This includes law enforcement and correctional personnel, truant officers, and others who by force of law or authoritative position require certain kinds of behavior. We have already noted how individual group members are affected in their group relationships by experiences with such personnel. We must now ask: Will it not be necessary to help youth groups modify their perceptions of such official law-related personnel and to help such personnel become postitively related to the youth groups if constructive growth is to be achieved as a result of our efforts with the group?

3. Another series of adult groups are perceived by delinquent youth as neutral or to be neutralized in relation to the goals of the youth group. Yet these are the same adult groups which the worker is apt to think of as resources and supporters of social health. These are the educational, character-building, and welfare agencies of the community. And again our problem as workers is to learn just how these positive forces in the community are perceived by the delinquent youth groups; and, if this perception interferes with important use of resources, how the perception can be changed in the direction of mutually beneficial relationships.

I am reminded of Tony, an adult parolee, who in telling about his childhood in Chicago revealed his picture of the community. There was his play group whose members joined in crashing theaters, stealing fruit as they lined up for the show, and wandering through the part of the city where "the aristocrats" lived. There was the truant officer, at first avoided and then flouted when Tony sold the car tokens provided for his transportation to school. There was the priest who changed his mind about Tony's possibilities for the priesthood when Tony stole $5 from him. And there was Tony's mother—deserted by his father—who wept while she served a sauceless spaghetti for Christmas dinner and who connived with Tony to outwit the truant officer.

For Tony his group of friends obviously offered the only association through which he could have fun and obtain other satisfactions. To this group the businessmen and property owners of the community were a race apart to be exploited. The representatives of the law were the enemy to be hated, avoided, and foiled. To Tony both his mother and the priest were dupes to be used so long as they were resources for gratification with no strings attached but to be abandoned when they made requirements based on their own goals.

Since the "community" of any group is composed of those persons and organizations which impinge in varying positive or negative degrees upon its goals the social diagnosis of any group must include a profile of that group's perception of its community. Does the group see the community as divided into admired power groups, authorities to be hated, and dupes to be exploited? Does it regard positively any adult organizations whose influence might be constructively directed? How can the group's negative perceptions of positive forces in the community be modified?

Finally, complete diagnosis of any group's potential requires a look into the way in which the group is perceived by the various segments of the community. Are some adult organizations purposely using the youth group as a recruiting ground for individuals to join in their antisocial activities? If they are, is there any way of neutralizing these forces so that they will not undermine the goals of the service? Are there other organizations, disregarded or exploited by the youth group, which could be interested in adapting their services to the needs of the group? Are there individuals and groups among the law-enforcement and correctional personnel who would welcome help in becoming positively related with a group that otherwise encourages and supports antisocial behavior in its members?

A useful analysis of the community demands attention to both how the adult groups' perceptions of the youth group can be modified and what interests in the adult groups can stimulate them to cooperate in efforts to meet the needs of the youth group.

In Summary

A useful understanding of any one hard-to-reach group of young people requires an examination of a constellation of relationships: the individual members as related to the group; the group as a social phenomenon; the group in its relationship with the community; and the community in its relationships with the group. A full exploration of these relationships should lead up to a design for effective service. Many such diagnoses of hard-to-reach groups can lead to a classification of groups and to a variety of plans for action based on differential understanding of the kinds of groups needing service. From such a variety of differentially designed plans we should be able more easily to develop a sound community strategy for reaching a larger number of the hard-to-reach young people in the delinquent subculture.

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FEEDING PROBLEMS OF CHILDREN WITH CLEFT PALATE

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VALUABLE INFORMATION may be at our fingertips, available only for the looking. This was demonstrated recently in Delaware when the State board of health's cleft palate-orthodontic clinic undertook a study of the eating habits and problems of children with cleft palate. Most important outcome of this study was the revelation of the ingenuity of parents in getting food into young children whose cleft was impeding their ability to take nourishment. Information on the feeding methods devised by these parents, through trial-and-error tactics, could be extremely useful to others faced with the same problems.

Since the cleft palate-orthodontic clinic team does not give overall medical and pediatric care, when the question arose concerning the feeding problems of children with cleft palate very little nutritional data were available from the clinic records. The general impression seemed to be that the eating habits of such children are similar to those of other children. It was to test this hypothesis and to discover if special nutrition services are pertinent to this group that the study was planned.

The clinic is held on a monthly basis. Its staff includes: a director, a coordinator of speech-and-hearing services, the chief medical social consultant—all from the board of health's division of crippled children's services; a public-health nurse from one of the county health units; one or more plastic surgeons from the A. I. du Pont Institute; and two or more dentists from a panel of three orthodontists and three prosthodontists associated with the clinic. On occasion, other members of the division's speech-and-hearing and social-service staffs are present, as are speech therapists from the State's educational system.

The board of health's nutritionist serves the team on a consultant basis. The nutritionist has not been included as a direct team member because of the wish to protect the children from too many interviews at the clinic and also to keep the team from becoming unwieldy.

Four to six children come to each clinic session, of which not more than two are there for the first time. The interim between visits varies depending on individual need. Some children come three times a year, and others only once in 3 years.

The age range of children coming to the clinic has changed over the years. When the clinic began in 1951, the majority were from 6 to 10 years old; none were under 3. As the program has progressed, greater stress has been placed on early evaluation and treatment so that an increasing number of children, when initially seen at the clinic, are in the younger age bracket. At the present time, the majority range in age from 1½ to 6 years.

In planning for the nutritional interviews with the parents and children, the team decided that a home visit was the most feasible way of getting the information desired. Since these children were known to the public-health nurses who give health supervision to the families, the nurse and the nutritionist were asked to make joint visits to the homes. The director sent a letter to the parents of each child on the clinic's roster to tell them of the intended visit and its purpose, and to ask for their cooperation in answering the staff's questionnaire. This proved to be a great help, as it prepared the parents beforehand for participation in the interview.

To date, 58 visits out of a possible 70 have been made. Among these the most commonly encountered problems were:

1. Among babies, insufficient suction to get the milk out of the nipple. Most of them learned to chew it out.

2. Excessive air intake on the part of infants, resulting in the need for several "burpings" during a feeding period.

3. Difficulty, among both babies and older children, in taking in liquids without choking.

4. Fear on the part of the mothers in facing the feeding task. Some mothers said they felt they transferred their fright to the child.

5. Annoyance from acid and spicy foods. Some older children refused carbonated drinks "because the fizz tickles my nose."

6. Trouble with some foods usually eaten by toddlers and older children—especially "gooey" or "pasty" foods—which seemed to get easily into the opening in the cleft. Those mentioned in particular were: nuts, peanut butter, leafy vegetables, peelings on raw fruit, cooked cheese dishes, and creamed foods. When food did get into the cleft, some children were able to suck it down; others rinsed it out with milk or water. Some had to have their mothers swab it out of the opening.

7. Difficulty in chewing, usually because of poor teeth. At least one-third of the children with which the interviews were concerned had this trouble.

Food coming out of the nose bothered some of the children but, in most instances, it worried other persons more than it did the child. Some families hesitated to take their child away from home to eat because of people's reaction to this occurrence.

One child hit on the method of using two fingers of the right hand to close the opening in the palate each time she swallowed a bite of food.

Many of these children remained on soft foods until after surgery. Some had difficulty with pureed foods. Some refused junior foods completely.

Successful Feeding Methods

The parents of these children had all found some ways of helping their children to increase their food intake.

Most parents found that holding a baby with cleft palate at a certain angle during feeding prevented the child from choking.

Some parents, while their babies were small, preferred a Brecht feeder or a medicine dropper rather than a regular bottle or spoon.

Parents who fed their afflicted child through a regular nursing bottle found enlargement of the nipple hole to be practically a necessity, unless an old, well-used nipple was available. They opened the holes with a heated needle or icepick, or with scissors or a razor blade. Sometimes they softened new nipples by boiling them.

Many parents found that pureed foods, if thinned with milk, fruit juice, broth, or other liquid, could be given from a bottle with a large hole in the nipple. They learned to place the nipple on the "good side" of the baby's mouth. Some found the bottle method more satisfactory than feeding from a spoon. On the other hand, some mothers found that their children could handle pureed foods better if they were thickened with the addition of crumbs of a vanilla wafer or graham cracker.

Many parents of children old enough to chew taught them to eat slowly in small bites to avoid regurgitation. They also learned not to give them foods which are apt to cause trouble, such as fried things and other crisp or hard items.

Some parents found that encouraging their child to suck liquids through a straw not only helped in the intake of food, but also helped to strengthen muscles for better speech.

The perseverance and ingenuity of some of the parents shone through their stories of how they managed to get food into these handicapped children while they were babies.

At feeding time, one mother held her infant on a pillow on her lap. She sat with her back to a window, so that the light would shine in the baby's mouth. Using a medicine dropper, she put one drop of milk at a time on the back of the baby's tongue and let it ooze down. One drop too much would strangle him. It took her an hour and three-quarters to give the baby 3 ounces of formula. She fed him every 3 hours day and night. She spent practically all her time with the baby since other persons were afraid to try the feeding. The father did the cooking and what housework was done.

Another mother reported that because she kept breaking the Brecht feeder, her husband had bought her a gadget that is used to put water in car batteries. She said that it was much cheaper and worked fine. She had to be careful to have the milk hit the inside of the infant's cheek; if it hit the back of his throat, he choked.

One couple had a baby girl with a cleft in both the hard and soft palates. When they tried to feed her, her tongue kept falling back and choking her.

FOOD INTAKE OF 49 CHILDREN WITH CLEFT PALATES

Servings per week		7 or more	4 to 6	2 to 3	1	None	7 quarts or more	7 to 9 pints	Less than 7 pints
Milk							14	18	17
Fruit	Citrus	10	5	23	8	3			
	Other	19	7	23	....	.....			
Vegetables	Leafy, green, and yellow	11	6	11	16	5			
	Other	11	5	....	....	.....			
Meat and fish		13	4	2	....	.....			
Eggs		9	22	15	....	3			
Bread and cereal		19	....	....	....	.....			
Dried beans		....	....	8	35	6			
Fats		49	....	....	....	.....			
Sweets		49	....	....	....	....			

The figures represent the number of children eating the servings of foods listed. The size of serving varied, depending on the age and activity of the individual.

After unsuccessful attempts to pull the tongue forward, they conceived the idea of turning the child on her stomach, across the mother's knee, with her head lowered. When she was in that position, her tongue came back to its normal place. Using a medicine dropper, these parents took 2 hours to feed the baby 1 ounce of milk. She kept losing weight, and when she was 4 months old weighed less than 6 pounds.

When the doctor was beginning to give up hope for this little girl's survival, the father hit on the idea of using a glass tube with a nipple on one end and a rubber bulb on the other. He heated a piece of neon tubing and shaped it so that the nipple and bulb could be used. A friend, who worked in a glass plant, made him several bottles, similar to the tubing, but with a greater capacity, and easier to use.

For 6 months this baby was not left alone day or night, even for a few minutes. When the time came for her to take solid foods, the parents gave her strained baby foods mixed with milk—one-half jar of baby food to 6 ounces of milk—through the bottle. They fed her from this special bottle for $2\frac{1}{2}$ years, until her cleft was mended through surgery. Now at 9, she is a happy, healthy individual.

Since eating was such a long drawn out process for many of the children with cleft palates, they were apt to get tired and give up before finishing a meal. Some choked easily, got panicky, and stopped eating. But the parents never gave up. One mother said that she had times when she thought she could not go through another feeding session. When she felt that way she would get up, walk around the table, count to 10, sit down again, and start over. Another mother solved the problem of tedium by feeding her child only small amounts, but frequently. One father told about having to keep patting his infant on the cheek so that she would stay awake long enough to take her formula.

Some mothers said they felt that they had been overprotective and suggested that other parents should be warned against this.

One mother who reported that she had never pampered her little girl, said she felt that as a result of this the child had become determined to learn to eat just like her brothers and sisters. By trial and error, she learned that she could not eat as fast or take bites as big as they, but she ate the same foods as the rest of the family.

Most of the mothers who had gone through the experience of feeding a child having a cleft palate said that they would have welcomed help and guidance in feeding methods and in the choice and preparation of foods. Those who were still undergoing the experience were eager to know how other mothers met the problems.

After Surgery

Surgery on the cleft had been performed on the majority of the children who were the subjects of the interviews. Most of their parents said the children ate better afterward and that eating was no longer such a chore for them. After surgery, the children had little difficulty with food coming out the nose. They also had fewer respiratory infections and, therefore, according to their parents, better appetities.

The children with prosthetic appliances for their clefts seemed to adjust to them very well. One or two had some initial difficulty in eating, as the appliances occasionally gagged them, but they soon learned to manage this problem. Some of these appliances helped the children in chewing and in keeping the cleft protected from food, as well as in speaking.

The children still having eating difficulties after surgery were the ones whose teeth showed marked decay or very poor occlusion, or both. Some of these children were old enough to have had orthodontic treatment. This, said their parents, had resulted in sufficient improvement in occlusion to be a real boon to the children's eating enjoyment by greatly alleviating the difficulty in chewing.

Diet Histories

The interviewers also attempted to find out what the current intake of food was for each child with a cleft palate. Each mother was asked to estimate how many servings per week her child ate of the following foods: milk and its products, fruit, vegetables, meat, fish, eggs, dried beans and peas, bread and cereal, fats, and sweets.

Diet histories were obtained on 19 children. Diets of many of the older children were unobtainable as some were away at school, some were institutionalized, and one was working away from home.

Milk intake was low in a large number of cases. Only a third of the children were drinking a quart daily. Fruit was well liked by most of the children, but in several cases the citrus fruits were not being made available to the child. Apples and bananas were favorites. Potatoes were eaten once or twice daily by the majority of the children. Those who did not eat potatoes usually had rice, spaghetti, or macaroni as a substitute. Many children disliked leafy, green, and yellow vegetables. Meat was well liked by practically all of the children, but in a few cases, family economy kept them from eating it daily. Only three children disliked eggs to the point of refusing them completely.

All of the children ate bread and cereals daily and several of them ate large quantities of such food. Cereal was a favorite between-meals snack. Dried beans were usually eaten when served. In the few cases where they were not eaten at all, the mothers said they never prepared them. Sweets in some form were consumed daily, in most cases in fairly large amounts. A few parents felt very strongly about the relationship of sugar to tooth decay and so restricted the amount of sweets being made available to the child.

About half the children were taking vitamin preparations, the majority in multivitamin capsules. Four were taking cod-liver oil during the winter months.

The eating pattern of these children in not taking enough milk, citrus fruit, and green and yellow vegetables is similar to the food habits of other children revealed by studies made elsewhere[1, 2, 3] and thus indicates a need for an educational effort emphasizing the place of such foods in the building and maintenance of health. Children with cleft palates especially need nourishing food, not only for normal growth and development but also for helping them to undergo the stress of surgery. Good nutrition is especially important for them because of its relationship to the prevention of dental caries and to the health of the gums.

As a result of the study, the nutritionist from the staff of the Delaware State Board of Health now accompanies the public-health nurse on a home visit to each child new to the cleft-palate clinic. Her purpose is to help the nurse to evaluate the child's eating practices and to work out helpful suggestions for the mother.

Also as a result of these findings, the nutritionist is now being given the opportunity to present to the clinic's team any nutrition information that seems pertinent to any particular case.

Already the findings of the study have been presented at an institute on the cleft-palate program. They will also be incorporated into a pamphlet for families of children with this handicap and to others who work in their behalf.

Since this study was undertaken, public-health nurses in Delaware have become more aware of the feeding problems facing children with cleft palate. Social workers have also expressed concern about the time consumed in the feeding and care of children with cleft palate and the possible effect this could have on their families. Speech therapists have expressed an interest in the relationship of nutrition problems to the success of their program. One cited the case of a child who made little progress with speech while in a poor state of nutrition but who responded well to speech therapy as soon as his nutritional status improved.

Less tangible, but also apparent, has been the study's significance in giving mothers of children with cleft palate a chance to discuss their problems and accomplishments and to exchange ideas with other parents in similar circumstances.

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THOSE WHO WERE LEFT BEHIND

On February 28, 1957, the Austrian Government issued a "stop order" on the further emigration of unaccompanied teen-agers from Hungary. This step had been urged by various international and national refugee-service agencies who feared that quick emigration might prevent sound resettlement planning for these young escapees or eventual reunion with their families. It was approved by the social agencies in this country which were experiencing difficulties in rapidly arranging satisfactory placements for Hungarian teen-agers in American foster homes.

However, a problem nobody faced was what would happen to the teen-agers thus cut off from resettlement. Now, 8 months since that "stop order" 1,100 of these young escapees, many of them former freedom fighters, are living in displaced persons camps or residential schools, forgotten lovers of freedom, for whose future no plan exists.

How this has affected some of them is suggested by the accompanying article, based on recordings which members of the Austrian Mental Health Society made for Betty Barton, of the Children's Bureau staff, in Vienna last August. Miss Barton was sent to Austria by the World Federation for Mental Health as a consultant to the society, which has been working directly with Hungarian refugees since they began to pour across the border into Austria a year ago.

THE TENSIONS among the Hungarian youth in Austria continue to mount because of the unceasing attempts of the Kadar government to entice them back to Hungary. Faked telegrams and telephone calls, as well as Hungarian newspaper articles sent to them regularly, put a constant pressure to return home on young people already in despair at their present existence of seemingly hopeless waiting.

The experience of one boy, Tibor, is typical. Last January, Tibor asked to go to West Germany because one of his cousins was studying there. As the attempts to arrange this have been very slow, the boy has become increasingly nervous and unstable, particularly since he receives a letter every other day, pleading for his return—supposedly from his father, a worker, but written in a highly intellectual style. The letters say that his mother is in delicate health, that his brothers and sisters miss him badly, and that his cousin has returned from Germany without any repercussions occurring. The boy, in a highly emotional state, had already asked to be sent home when he received a letter from his cousin, still in Germany, saying that he had no intention of returning to Hungary.

Then there is Lisbeth, a 16-year-old girl, who fought and nursed the wounded in the Budapest uprising and who hoped to go to the United States to study medicine. This desire had been instilled in her by her father, who had disappeared in the revolution after 7 years of imprisonment by the secret police. Her stepfather, a Communist functionary whom her mother had married after divorcing her father, was exerting heavy pressure on Lisbeth to return home. She was at first firm in her refusal. However, after learning that she could not go to the United States and being taken to a home for girls, she began to show signs of serious emotional conflict. This girl, who has very little chance of ever being given an opportunity to study medicine anywhere and who has been unsuccessful in numerous attempts to learn what has become of her father, is near the breaking point. She has twice tried to commit suicide.

The growing symptoms of hopelessness among the young Hungarians have undoubtedly been aggravated by the entanglements of red tape unwittingly

spun by those government bodies and the international agencies in whose hands their future lie: the Austrian Government; the governments of the countries of hoped-for destination and their consulates, often administratively harassed by their governments' changing policies; the office of the United Nations High Commissioner for Refugees; the Intergovernmental Committee for European Migration; the International Social Service; and the 3 religious and 1 nonsectarian voluntary international refugee-service agencies. But even policy changes which require additional waiting might not be so bad if whatever information the young people received carried the ring of certitude. As it is, no one among all the people and agencies working with the Hungarian refugees is a repository of all authoritative information and so able to dispel rumors and straighten out the conflicting statements of various authorities or even of various representatives of the same authority.

Thus the "runaround" experienced by one boy, Janos, is unhappily not unusual. This 16-year-old heard by the grapevine while at a vacation camp for Hungarian youth in the Tyrol of changes in regulations for emigration to the United States which increased his chances of emigrating soon. When he got back to his "youth home" he went at once to the nearest representative of the refugee agency handling his case, so that he would not miss this opportunity. There, however, he was told that the United States regulations had not been changed. Undaunted, he hiked the 180 miles to the agency's headquarters in Vienna, where he learned that the rumor he had heard was based on fact. However, he also learned that he would have to return for action on his case to the agency's local representative, who had already rebuffed him.

The Effects of Uncertainty

Thus, young people who were kept out of a quick move to a country of second asylum by the "stop order" of last February, as a protection from unwise decisions, have been subjected to months of uncertainty and confusion. Even those who have been able to produce parental consent to their further emigration, and so have been cleared for the case-by-case planning which the agencies had envisioned, have been blocked by the fact that in the intervening months the countries they had hoped to enter have shut their gates almost tight to any but close relatives of persons already residing within them or to persons with specific skills.

The story of Laszlo is unfortunately all too familiar and is true, with minor variations, of Bela, Josef, Pal, and a host of others. Laszlo escaped from Hungary at the age of 16 a few days after the revolution collapsed. Last February he managed to obtain written permission from his parents to go to the United States. However, he got caught in the stop order, and while he waited disconsolately in Traiskirchen, a large camp, the letters from his parents arrived farther and farther apart and finally ceased. After not hearing from his family for 4 months he became so worried that he returned to Hungary to try to find out what happened to them.

The Youth Homes

The young people have been moved from camp to camp or from camp to school. These camps and schools are run by the Austrian Government's Innen Ministerium, the arm of government responsible for safeguarding the nation's inner security, and hence inevitably have a police orientation. Some of the young people are getting vocational or language training that may be useful to them in the future. Many are not. A survey of the schools or "youth homes" by two psychiatrists, one Austrian and one Hungarian, shows wide variety and lack of any basic standards.

The tendency, however, is toward strict authoritarian administration, which is imposing the type of rules generally made for children on young people most of whom, although still under 17, had in Hungary been working in mines and factories and been accustomed to living as adults. Moreover, since many of these schools are 50 or 60 miles from Vienna, where the offices of the consulates and refugee agencies are located, the ability of the young people to learn about the latest changes in the emigration picture or to make inquiries about their own emigration status is hampered.

One youth home, for instance, is headed by a woman who locks the young people out of their rooms in the morning after breakfast, although the home has no program of activities to occupy them. All their letters are opened, and sometimes even their papers of parental consent to emigration are taken away from them as a disciplinary measure. Such procedures have naturally aggravated the disciplinary problems in an already restless group of young people.

It is therefore not surprising that in restlessness and despair many young Hungarians have returned to Hungary, perfectly aware that this is for them perhaps a form of suicide. It is estimated that 1,000

teen-agers have gone back either by their own decision or through the encouragement of the local Austrian officials, including some of the youth-home personnel, who are understandably anxious to rid themselves of difficult disciplinary problems.

Sandor, aged 17, was one of them. He went back to Hungary in July after waiting since last December to join a cousin in the United States. Sandor's mother and other members of his family had written to him warning him not to go back to Hungary no matter what happened and telling him of a friend who had disappeared shortly after his return. Although Sandor left word with his friends that he would send them a message after his return, no further word of him has been received.

While it is difficult to get documentation on the persecution of those who return to Hungary, the silence of those who have gone bears grim testimony as to their reception. Moreover, people who have come to Austria from Hungary tell stories of what happens, although they will not put them in writing because of fear of the consequences to their friends and relatives back home. These stories are of three types: (1) the boy or girl never appears at his own home and news of his death may or may not eventually arrive; (2) the young person arrives at his home, and is later taken away by the police and "treated for espionage"; (3) a girl arrives home and is unmolested but is required to write letters back to her Hungarian friends in Austria saying that she is being well received and urging them to come back. This last treatment seems to be reserved for girls.

Occasionally a card with a cryptic message gets through. One was received by a woman in Austria who had urged the young Hungarians in camps and youth homes to be patient. It came from a concentration camp in Hungary and was signed merely "Istvan," a name too common in Hungary to identify the owner. Its only message was "How right you were!"

Guides and Reports

GUIDE FOR PLANNING AND OPERATING AN ADOPTION RESOURCE EXCHANGE. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. 1957. 19 pp. $1.

Suggests how a State public welfare department can help bring together the hard-to-place child and the would-be adoptive family by conducting a clearinghouse for adoption agencies located in different parts of the State. The material is based on the experience of the six States now operating such exchanges.

THE EVALUATION AND TREATMENT OF THE MENTALLY RETARDED CHILD IN CLINICS. National Association for Retarded Children, 99 University Place, New York 3, N. Y. 1956. 132 pp. $1.25 per copy; 10 or more copies, $1 each.

Papers given at a professional training institute, held March 14–17, 1956, in New York City, sponsored by New York Medical College and the National Association for Retarded Children.

THE CHURCHES AND JUVENILE DELINQUENCY. Robert and Muriel Webb. Association Press, New York. 1957. 64 pp. 50 cents.

Suggests some ways in which churches may work toward preventing delinquency.

MENTAL HEALTH AND SPECIAL EDUCATION. Edited by William F. Jenks. Catholic University of America Press, Washington 17, D. C. 1957. 235 pp. $3.50.

Proceedings of the workshop on mental health and special education conducted at the Catholic University of America, June 15–16, 1956.

BABY SITTERS: a basic training manual for sitters, parents, schools, community leaders, and youth organizations. National Board of Young Women's Christian Association of the United States of America, 600 Lexington Avenue, New York 22, N. Y. 1957. 40 pp. 25 cents.

Outlines basic units of a babysitting course, including facts on child development, and provides information on written and audiovisual materials for use in the course.

CASEWORKER AND JUDGE IN NEGLECT CASES. Robert M. Mulford, Victor B. Wylegala, Elwood F. Melson. Child Welfare League of America, 345 East 46th Street, New York 17, N. Y. 1956. 31 pp. 60 cents.

Presents 3 papers—2 of them by juvenile-court judges—planned to guide caseworkers in taking court action for the protection of children who are physically or emotionally neglected.

SERVICES FOR CHILDREN WITH VISION AND EYE PROBLEMS. Prepared jointly by the Committee on Child Health of the American Public Health Association and the National Society for the Prevention of Blindness. 112 pp. $1.50. 1956.

SERVICES FOR CHILDREN WITH HEARING IMPAIRMENT. Prepared by the Committee on Child Health of the American Public Health Association. 124 pp. $1.50. The Association, 1790 Broadway, New York 19, N. Y. 1956.

Two guides in a series for health workers organizing services for children with various disabilities.

BOOK NOTES

SOCIAL CASEWORK: a problem-solving process. Helen Harris Perlman. University of Chicago Press, Chicago. 1957. 268 pp. $5.

The author, a professor at the University of Chicago's School of Social Service Administration, presents this book as a text on the practice of social casework for students, beginning caseworkers, and teachers and supervisors, and as a refresher guide for experienced, skilled workers.

Describing the components of casework as (1) the person seeking help in solving a problem, (2) the problem itself, (3) the social agency to which he brings the problem, and (4) the process of helping him solve it, the author analyzes each; discusses the relationship of caseworker to client; and sets forth a framework for their joint efforts toward problem solution.

She then discusses techniques for involving the client in the beginning phase of the casework process; the purpose and content of dynamic, clinical and etiological diagnosis; the client's involvement in the treatment process—his motivation, responsiveness, and ability to use help; and the caseworker's immediate and eventual goals.

Two cases are presented as illustrations of the process.

HALF THE WORLD'S CHILDREN; a diary of UNICEF at work in Asia. S. M. Keeny. Foreword by Maurice Pate. Preface by Danny Kaye. Association Press, New York. 1957. 254 pp. $3.50.

The story of the United Nations Children's Fund is easy to tell, says the author of this book, because it deals with children. As he relates the events of his first 7 years as UNICEF's regional director for Asia, all sorts of things that interested or amused him creep in, so that people—fathers, mothers, children, and government officials as individual human beings—gleam through reports on the accomplishments of an organization.

During this time UNICEF's efforts were concentrated on helping governments work toward: eradicating malaria, yaws, trachoma, tuberculosis, and leprosy; making childbirth safer for mothers and babies through better midwifery; seeing that children receive milk daily; and feeding peoples who were starving as a result of national disasters.

Among the steps taken toward those objectives, as noted by the author, were such jobs as warring against the contamination of BCG vaccine by white ants; manufacturing of DDT to combat malaria-carrying mosquitos and of penicillin to cure yaws; drying buffalo milk; and planning factories to produce soy "milk" as a comparatively inexpensive replacement for the powdered skim milk now sent by UNICEF from the United States.

By the end of 1956 the number of tuberculin tests given to children in Asia had reached 148 million, and the number of BCG vaccinations 52 million. Examinations for yaws had totaled 68 million, with 6.4 million persons treated. About 6,000 centers for mothers and children had been equipped and were being supplied with drugs and milk. The campaigns against malaria had expanded, largely with United States aid, to protect nearly half of the 300 million people who need it.

For these achievements, says the author, first credit goes to the Asian governments. A good share goes to WHO and FAO whose experts helped to guide the projects in their difficult first stages. "That the jobs could be done at all," he says, "was because we all worked as a team."

PATTERNS OF CHILD REARING; a report on ways of bringing up children. Robert R. Sears, Eleanor E. Maccoby, and Harry Levin, in collaboration with Edgar L. Lowell, Pauline S. Sears, and John W. M. Whiting. Row, Peterson & Co., Evanston, Ill. 1957. 549 pp. $5.25.

Through recorded interviews with 379 mothers of 5-year-old children, the study reported in this book sought answers to three questions: (1) How were the mothers rearing their children? (2) What effects did their different methods of rearing have on the children? (3) What led the various mothers to use one method rather than another?

Seven factors in the mothers' child-rearing practices were selected for study: degree of permissiveness or strictness; general family adjustment; warmth of mother-child relationship; responsible orientation of the mother to child training; aggressiveness and punitiveness; mother's perception of her husband; and her orientation to the child's physical well-being. The most pervasive of these factors, the study showed, was warmth.

The study, which was part of a larger study undertaken by the staff of the Laboratory of Human Development of the Graduate School of Education of Harvard University, was made in two suburbs of Boston and included families of several ethnic backgrounds and of varying socioeconomic status.

EDUCATION AND HUMAN MOTIVATION. Harry Giles. Philosophical Library, New York. 1957. 108 pp. $3.

This book presents an integrated theory of human development with the purpose of helping workers in various disciplines to interpret their research findings jointly and in such a way as to allow each discipline to contribute its own emphases without losing the advantages inherent in specialization. Stressing the idea that human beings constantly struggle for freedom to grow and achieve all their possibilities, the author, who is director of the New York University Center for Human Relations Studies, maintains that the chief condition of that growth is "belonging."

For Parents

WHEN YOUR CHILD IS ILL. Samuel Karelitz. Foreword by Bela Schick. Simon & Schuster, New York. 1957. 485 pp. $4.95.

This book is planned, the author says, to help parents find answers to routine questions of the kind that they usually ask the pediatrician by telephone. The subjects taken up include allergy, viruses, fever, the wonder drugs, immunization, and hygiene; "general diseases," such as chickenpox, diphtheria, and measles; respiratory diseases and re-

lated conditions; diseases of the nervous system; intestinal diseases; diseases of the mouth and eyes; skin conditions; and venereal diseases. A glossary and blanks for health records are included.

YOUR CHILD'S TEETH; a guide for parents. Edgar S. Bacon. Foreword by C. Raymond Wells. E. P. Dutton & Co., New York. 1957. 124 pp. $2.50.

This comprehensive instruction book for parents discusses such subjects as tooth formation, teething, home care of the teeth during babyhood and childhood, visits to the dentist, food in relation to tooth decay, gum diseases, and mouth habits such as nailbiting. It includes a chapter on dental-health programs for children and a section containing more than a hundred questions and answers on the subjects taken up in the book.

A VISIT TO THE HOSPITAL. Francine Chase. Pictures by James Bama. Prepared under the supervision of Lester L. Coleman. Introduction by Flanders Dunbar. Grosset & Dunlap, Inc., New York. 1957. 68 pp. $1.50.

Addressed to both parents and children, this book is planned to help prepare a child emotionally for a tonsillectomy and a hospital experience by telling him ahead of time what to expect.

RETARDED CHILDREN CAN BE HELPED. Cornell Capa and Maya Pines. Channel Press, Inc., Great Neck, N. Y. 1957. 159 pp. $5.

What parents of retarded children can accomplish by combining their efforts is suggested in this book, which describes a number of achievements by small groups of parents: a diagnostic clinic; home training by visiting nurses; schooling for the "trainable" as well as the "educable"; suitable paid employment for retarded adults and young people; the teaching of social graces; the improvement of a State institution; and the development of a comprehensive county program for the retarded. The book also describes a "model" institution, "in which happiness comes first"—Southbury (Conn.) Training School.

In accordance with the belief of parents' associations that mental retardation is not something to be hidden away, true names are used throughout and numerous photographs are included.

International Publications

STUDY GROUP OF PAEDIATRIC EDUCATION: Report. WHO technical Report Series, No. 119. World Health Organization, Palais des Nations, Geneva. 1957. 20 pp. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N. Y. 20 cents.

This report presents the objectives and the role of pediatrics in medical education, outlines the content of a pediatric curriculum in a medical school, and discusses time allotment, teaching methods, and assessment of the teaching program. It also discusses various forms of postgraduate training in pediatrics, including the training of the public-health specialist in child health. One section is concerned with organization and relationships of a department of pediatrics and recommends that such a department be an autonomous unit of the medical school.

The report also contains a section, with specific suggestions, on the role international agencies can play in lending support to the improvement of teaching programs in pediatrics everywhere.

The study group which drafted this report is composed of 13 pediatricians from 12 countries. Throughout their report they have emphasized the importance of teaching facts about normal growth and development and the preventive and social aspects of pediatrics.

ACCIDENTS IN CHILDHOOD; facts as a basis for prevention. Report of an advisory group. WHO Technical Report Series No. 118. Palais des Nations, Geneva. 1957. 10 pp. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N. Y. 20 cents.

Among the measures recommended in this report by the World Health Organization's Advisory Group on Accident Prevention in Childhood are: collection of information on nonfatal as well as fatal accidents; more rapid reporting and processing of accident-mortality data and more useful grouping of such data; evaluation of data to discover significant accident problems masked by low mortality; relating the incidence of accidents to the populations exposed to them and whenever possible to the frequency of such exposure; inquiry into the social and other circumstances surrounding the accident victims; and thorough and uniform recording of all the information.

The report lists three categories of accident-prevention methods: education of children in self-protection; education of groups concerned with safe environment, such as town planners, architects, and toy manufacturers; and enactment and enforcement of safety laws and regulations.

DISCUSSIONS ON CHILD DEVELOPMENT; a consideration of the biological, psychological, and cultural approaches to the understanding of human development and behaviour. Edited by J. M. Tanner and Bärbel Inhelder. Proceedings of the first two meetings of the World Health Organization Study Group on the Psychobiological Development of the Child. Vol. 1, the first meeting, at Geneva, 1953, 240 pp.; vol. 2, the second, at London, 1954, 271 pp. International Universities Press, New York. 1957. Set of two, $10.

The first volume of these proceedings includes discussions of physical and physiological aspects of child development; behavior of newborn babies with various degrees of anencephaly; stages of development; animal behavior; use of electroencephalography in child-development study; stages of psychological development; instinct; and cross-cultural approach to child-development problems. The discussions reported in the second volume are centered around a common theme, learning, with special reference to learning under stress and to learning in the immature organism.

HANDBOOK OF VITAL STATISTICS METHODS. Studies in methods, Series F, No. 7. Statistical Office of the United Nations, Department of Economic and Social Affairs, New York. 1955. 258 pp. $2.50.

Presents a worldwide cross-section of practices, procedures, and methods, both administrative and statistical, used in connection with records and statistics of live births, deaths, stillbirths, marriages, and divorces.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

A CITY DECIDES. 27½ minutes, sound, black and white, purchase or rent.

Illustrates some steps toward integration of Negro and white pupils in a public high school in Saint Louis, including discussion of possible future conditions in the school by a group of parents before the school term began. Shows successful operation of a teacher's hands-off policy in his own classroom.

Audience: Teachers, nurses, social workers, and other professional groups concerned with high-school children.

Produced by: Charles Guggenheim & Associates, for the Fund for the Republic.

Distributed by: Contemporary Films, 13 East 37th Street, New York 16, N. Y.

PHYSICAL REHABILITATION. 28 minutes, sound, black and white or color, purchase or rent.

Shows handicapped children in a convalescent home learning to do the ordinary things of daily life that their handicaps make difficult.

Audience: Parents of handicapped children; general public; professional workers for the handicapped.

Produced and distributed by: Film Originals, Box 4072, Boise, Idaho.

UNCONDITIONAL SURRENDER. 24 minutes (also a 14-minute version), sound, black and white, loan.

Shows how polio vaccine is manufactured and illustrates the licensing procedures at the National Institutes of Health, Public Health Service, Department of Health, Education, and Welfare.

Audience: Adults and high-school and college students.

Produced and distributed by: Division of Public Education, National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

SCHOOL SOCIAL WORKER. 25 minutes, sound, black and white, sale or loan, with charge for service and transportation.

Illustrates how the school social worker cooperates with parents, teachers, and others in helping children solve social problems that interfere with their school adjustment.

Audience: Parent-teacher groups, high-school and college students.

Produced by: University of Southern California, Department of the Cinema.

Distributed by: University of Southern California, Audio-Visual Services, University Park, Los Angeles 7, Calif.

THE INVADER. 37 minutes, sound, black and white, purchase or rent.

Highlights the fact that in spite of new methods of treatment and more enlightened public attitudes, syphilis has not yet been wiped out.

Audience: Teen-agers.

Produced by: Potomac Film Producers.

Distributed by: Center for Mass Communication, Columbia University Press, 1125 Amsterdam Avenue, New York 25.

BIOGRAPHY OF THE UNBORN. 17 minutes, sound, black and white, purchase.

Shows development of the human embryo from conception to birth, mainly through simple drawings.

Audience: Prospective parents; students of the sciences.

Produced and distributed by: Encyclopedia Britannica Films, 1150 Wilmette Avenue, Wilmette, Ill.

ASSIGNMENT CHILDREN. 20 minutes, sound, color, rent.

Danny Kaye shows how UNICEF works in various parts of the world to prevent and cure yaws, tuberculosis, malaria, and other diseases affecting children.

Audience: Adults, professional or lay.

Produced by: United Nations International Children's Fund.

Distributed by: Association Films, 347 Madison Ave., New York 17, N. Y.

CHILDREN'S FANTASIES. 22 minutes, sound, black and white, purchase.

Suggests how the fantasies of young children, such as those due to fear of darkness, can be channeled into some form of creative activity.

Audience: Parent groups.

Produced by: Crawley Films.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

PARENTS ARE PEOPLE, TOO. 15 minutes, sound, black and white, purchase.

Presents both sides of the case of parents vs. teen-agers. Suggests that thoughtful evaluation of the actions that parents nag young people about can result in a mutual wish for self-improvement.

Audience: Parents; teen-agers.

Produced and distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

THE SEARCH, "Stuttering." State University of Iowa. 25 minutes sound, black and white, purchase or rent.

Shows treatment of stutterers at a speech clinic, emphasizing the psychological basis of stuttering.

Audience: Parents, teachers, professional health workers, and stutterers.

Produced by: Columbia Broadcasting System for television.

Distributed by: Young America Films, 18 East 41st Street, New York 17, N. Y.

Photo Credits

Frontispiece and pages 207 and 216, U. S. Public Health Service.

Page 216, North Carolina Board of Social Welfare.

Pages 220 and 222, New York City Youth Board.

Page 237, right, Suzanne Szasz.

PROJECTS AND PROGRESS

World Federation for Mental Health

Over 600 persons from 32 countries attended the 10th annual meeting of the World Federation for Mental Health, which was held in Copenhagen August 11 to 17, with the theme "Growing Up in a Changing World." They represented a wide range of the helping professions and the behavioral sciences as well as lay interest in promoting mental-health programs.

The conference, in plenary sessions, discussion groups, and film reviews, explored the process of "growing up" from many standpoints.

In her presidential address, Dr. Margaret Mead, anthropologist, of the United States, declared that the field of human development now has a great deal of material about the way in which the human organism matures, the kinds of individual differences that are found among infants, children, and adolescents and the characteristics of different periods of growth. She also noted that studies of various societies indicate the extent to which all known human societies have been willing to sacrifice some of their children, through practices varying from a savage tribe's putting to death all identical twins, to the apparent acceptance today in the United States of an expectation of a million juvenile delinquents by 1960. With the resources of knowledge, training, and wealth now available it should no longer be necessary for any society to sacrifice any of its children, she said.

The conference proceeded to identify the resources of knowledge from the various disciplines which could contribute to a better understanding of the needs of the maturing child. Much rethinking is needed, an Australian psychiatrist said, in regard to the large mass of advice that is given in the field of child care. He suggested that in the meantime a start might be made toward freeing responsible parents and their "expert" advisers from the weight of rigid practices by increasing their incentive to understand more of unconscious motivation, theirs and the child's.

A Danish psychologist discussed the concept of "school maturity." Among factors which, when combined, constitute school maturity he named: general intelligence; ability to work with symbols (numbers and letters); ability to follow an order given to a group; ability to work for a relatively long period with the same kind of problems; and last but not least, the ability to work in a group and to cooperate with other children. Children of about the same chronological age may differ widely in school maturity, this psychologist said, pointing out that it is quite normal for plateaus to occur in the learning curve.

The juvenile delinquent, an individual described as having dramatized his resistance to "growing up" in terms of his own culture, received considerable attention. A professor of psychiatry from China contrasted two types of youth groups in Taiwan: the *Tai-pan* or modern juvenile delinquents much akin to their western prototypes; and the *Liu-mang*, youthful vagrants or lawbreakers, long known in Taiwan society. Their differences he ascribed to two existing subcultures—the "modern" and the "traditional."

The problems created for adolescents coming from socially disorganized urban slums who are placed in foster families with rather rigid standards of accepted social and sexual behavior were illustrated through case histories by an American psychiatrist. He pointed out that, unlike adoption, foster care does not provide a deidentification with the natural family nor does it give the full security of permanency in the foster home. He describes an experiment in New York City in which the dynamics of interaction in a peer group and of individual counseling were combined in order to provide a group of uprooted adolescents living in foster homes with greater opportunities for ego growth.

Difficulties in adjustment experienced by another type of uprooted adolescent were analyzed by a Dutch psychiatrist, who described the problems and reactions of Hungarian youth who have recently come to the Netherlands as refugees. His observations indicated that the young refugee goes through a number of emotional phases in integrating into the new culture so that as he makes his own readjustments his needs are continually changing and require concurrent modification in the help offered to him.

Implicit in the conference theme was recognition of the wide range of changes that are taking place in the world as the result of expanding knowledge. Energy was directed to finding ways of meeting these changes and of adapting present knowledge to the world of today and tomorrow.

In 1958 the World Federation for Mental Health will meet in Vienna in August, with the theme "Flight and Resettlement." Its purpose will be to consider the mental-health problems of refugees.

—Betty Barton

Inter-American Institute

The 38th meeting of the American International Institute for the Protection of Childhood, held July 19–August 3 in Lima, Peru, marked a turning point in the agency's history, since it: (1) adopted new statutes; (2) changed its name; (3) approved a new internal structure and more forward-looking work program; and (4) elected new officers and a director general.

Second oldest among the specialized agencies of the Organization of American States, the institute was inaugurated in Montevideo, Uruguay, in 1927. By joint resolution of Congress, the United States joined in 1928, and all American Republics are now members. According to the revised statutes, it is a "center of information, study, documentation, consultation, advice, and social action on all problems relating to maternity, childhood, adolescence, and the family, in America." Its new name is: Instituto Interamericano del Niño—or Inter-American Children's Institute.

The institute will operate through a central bureau, including a technical department, a statistical unit, and a division of library and publications. Advisory committees on pediatrics, education, statistics, legislation, and social services will assist the technical department, especially in formulating recommendations for the work program. The quarterly, *Boletín*, is to be modernized and the institute will emphasize development of teaching materials, in-

cluding translations. A beginning has been made with a Spanish version of the Children's Bureau leaflet, "The Child Who Is Mentally Retarded."

The institute's staff is small. However, the budget provides for hiring experts under contract. Thus, if a country requires direct technical assistance, the institute can make an expert available. Short-term experts are also hired to work on basic studies, such as the comparative study of legislative provisions affecting children in the 21 American Republics, initiated in 1956. The statistical unit is currently studying obstacles to birth registration.

For the past 5 years the institute had participated in the technical-cooperation program of the Organization of American States through a series of workshops, held at the headquarters in Montevideo and in each of the American Republics. A new project, approved at Lima for submission to the next meeting of the OAS's Technical Cooperation Board, next February, would establish a training seminar for crippled children's services in the rehabilitation center in São Paulo, Brazil.

In the work program for 1958, first priority was given to two symposiums on child nutrition, to be carried out in cooperation with the Unitarian Service Committee, the United Nations Food and Agricultural Organization, the Pan American Sanitary Bureau, and the Nutrition Institute of Central America and Panama. The first of these will be held in Cali, Colombia, in February 1958. A seminar on institutional care was also approved.

—Elisabeth Shirley Enochs

Mental Health

A study of the role of schools in promoting mental health is one of 12 studies being carried on by the Joint Commission on Mental Illness and Health. The study will examine existing criteria for "good schools" and "good mental health"; develop new criteria for such concepts; determine the educational and mental-health expectancies of groups with a variety of social backgrounds; and draw conclusions assessing the present effect of school programs on mental health which are pertinent to various professional services and suggestive of further research.

Like the commission's other studies, the school mental-health study is financed mainly by grants from the National Institute of Mental Health, U. S. Department of Health, Education, and Welfare. Also contributing to the study's financial support is Harvard University's Graduate School of Education.

Shortly after its formation in 1955 the commission was designated as the group to receive Federal funds authorized by Congress in the Mental Health Study Act of 1955 for an evaluation of this country's mental-health resources. Among the other parts of this project already under way are studies of: patient care; rehabilitation of discharged patients; nonpsychiatric community resources; causative factors in mental health; research needs and operations; the sources and training of personnel; self-help organizations of former mental patients; the epidemiology of mental illness; the role of religion in mental health. The project also includes a sample survey of people's ideas of their emotional problems and what they do about them.

The commission is composed of 12 persons professionally concerned with mental health. Participating in its activities are 34 national organizations, voluntary and governmental, including three units of the Department of Health, Education, and Welfare—the Children's Bureau, the Office of Vocational Rehabilitation, and the National Institute of Mental Health.

Radiation

Because of the harmful genetic effects of radiation, methods must be found for recording amounts of radiation to which individuals and populations are exposed, however difficult this may be, in the opinion of the World Health Organization's Study Group on the Effect of Radiation on Human Heredity. In its report, recently issued by WHO, the group maintains that strong grounds exist for believing that "a small amount of radiation received by a large group of individuals can do an appreciable amount of damage to the population as a whole."

Expressing concern about the genetic hazards from radiation sources used in medicine, industry, commerce, and experimental science, the report stresses the need for intelligent use of diagnostic and therapeutic X-rays or radioisotopes so that the maximum benefits may be gained and long-term genetic hazards reduced to a minimum. The group also urges that consideration should be given to determining what efficient means of shielding the gonads in medical X-ray procedures could be devised and brought into general use, and recommends that the X-ray beams in such procedures be directed so that as little radiation reaches the gonads as is possible under the circumstances.

In addition to its findings the report includes working papers of the study group and other documents.

School Integration

Studies of five communities which suffered outbreaks of violence over school desegregation in 1956 have been made by the Anti-Defamation League of B'nai B'rith with the view of learning what contributed to the outbursts and what might have prevented them. Reports of four of these studies—those of Sturgis, Ky., Clinton, Tenn., Beaumont, Tex., and Mansfield, Tex.—have already been issued and the fifth, of Tallahassee, Fla., is in preparation.

All four of the reports indicate that more careful planning before the meeting of the races in schools was attempted might have been effective in forestalling trouble.

The report on Clinton offers advice to communities wishing to avoid this town's difficulties. Among others are these suggestions:

1. Include all economic and social levels in preparatory efforts toward desegregation; and plan these to cover the entire county rather than just the town where integration is to take place.

2. Make sure that local public officials and law-enforcement agencies are aware of the provisions of applicable laws and are prepared to enforce them.

3. Remind the community of the moral rightness of desegregation—not merely of its legal status.

4. Try to keep students from joining street mobs.

Copies of each report may be had at 25 cents from the League, 515 Madison Avenue, New York 22, N. Y.

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Some classroom practices that teachers can use to help children adjust to desegregation are listed in a pamphlet prepared recently under the supervision of a committee of the Society for Psychological Study of Social Issues. Among others are:

Including subject matter that focuses on the meaning of group differences and their place in a democratic society; providing opportunity for discussion of

desegregation, so that every pupil has a chance to express his feelings; using group techniques that help youngsters get to know one another while learning; avoiding derogatory statements about any race or other group; and using role playing to help pupils understand how those of a different race feel in interpersonal contacts.

The pamphlet, "A Guide to School Integration," by Jean D. Grambs, also includes advice on community planning for desegregation. It is one of a series on intergroup relations available at 25 cents each from the Public Affairs Committee, 22 East 38th Street, New York 16, N. Y.

Youth Participation

Noting that more than 90 percent of the youths in the State are not delinquent and that many of them are a constructive force toward community betterment, the Maryland Commission for the Prevention and Treatment of Delinquency recently recommended to the Governor that young people be given opportunity for greater contribution in planning and executing community activities that affect their age group. The young should be included, the commission maintains, in the commission's own activities; also in the work of local youth commissions; of the Governor's conferences on delinquency; of community councils; and of boards of agencies concerned with youth; as well as in planning by local operating groups in the youth field.

About Polio

An 80 percent reduction in paralytic poliomyelitis over the past 2 years is reported by the U. S. Public Health Service. Summarizing the polio picture as of October 1957, the Service reports 1,576 paralytic cases occurring in 1957, compared with 7,886 for the same period in 1955 and 5,241 in 1956.

Only 63 cases of paralytic polio were reported in 1957 among the 28 million persons who received three shots of vaccine, the number recommended.

Although the vaccine is designed to prevent paralytic polio, the number of polio cases of all types showed a sharp reduction in 1957. By October 4,851 cases had been reported, compared with 21,667 in 1955 and 12,146 in 1956. The average number of cases during the period 1952–1956 was 24,928.

The Public Health Service estimates that of the 67 million persons in the priority group in this country those under 20 years of age and those who are pregnant 25 million have received all three injections; 22 million, two injections; 11 million, one; and 9 million, none. The Service urges that attention be given particularly to vaccinating teen agers.

Nutrition

How a child learns to eat and what an adult can do in furthering this developmental process were the questions occupying major attention at a Conference on Child Feeding held at the Arkansas Medical Center in Little Rock last spring. Financed by the Arkansas State Board of Health, the Arkansas Dietetics Association, and the American Institute of Baking, the conference was sponsored jointly by the Child Care Association of Greater Little Rock, the Pulaski County Home Economics Association, and several statewide organizations: the Academy of Pediatrics, Dietetic Association, League for Nursing, School Food Service Association, and Board of Health. Among the 174 persons who attended were physicians, nurses, dietitians, and other persons connected with nursery schools, kindergartens, child-care institutions, and school-lunch programs.

Led by Dr. Miriam E. Lowenberg, the discussion stressed among other points the importance to children's eating habits of: adults' attitudes toward food; variety in menu; food texture; appropriateness of servings in relation to the child's age and appetite. They also advocated early nutrition education in the schools and efforts to broaden parent participation in school-lunch programs.

Child Welfare

In an effort to determine how many child-welfare workers are needed to provide adequate services to all the children under its care, the Louisiana State Department of Welfare recently made a statistical study of contacts made by caseworkers with children in foster care, the largest program in its child-welfare division. The study was based on a 10-percent sample of the 2,500 children in the foster-care program, which, according to a 1955 time study, takes three fourths of the child welfare workers' time.

The contacts counted were those made during a specified 3 month period and those which the caseworkers in conference with their supervisors predicted would have to be made in the 3 months following. An analysis of the data indicated that if adequate services were to be given, the number of contacts in the 3 months following would be nearly double the number made during the base period. Used in conjunction with some of the findings of the 1955 time study, the data indicated that the department would have to increase its child-welfare staff by 30 percent.

The study also showed that children with major emotional problems had more than twice as many contacts with a caseworker than did children whose problems were considered negligible.

* * *

Case records of 200 children and young people in serious difficulty with the law were analyzed recently by the Citizens' Committee for Children of New York City as a step toward defining a comprehensive community plan for helping troubled children before they come to the attention of what the committee calls "late-stage" agencies—courts, institutions, and the city's youth board.

In 147, or nearly three-fourths of the cases analyzed, the study staff found that there had been indications of something being wrong in the life of the child at least 2 years before the incident occurred that brought him to the attention of the "late-stage" agency. At that earlier time most of these young people and their families were already known to a number of health and welfare agencies, but, according to the committee, these early contacts usually represented "opportunities lost."

The committee reports that its findings show that neither public nor voluntary services in the city are dealing effectively enough with all children in trouble. It blames this shortcoming on staff shortages and on insufficiency of detention and shelter space, of good foster homes, and of outpatient facilities for psychiatric diagnosis and treatment. An effective program, the committee maintains, will require changes

not only in the organization of social services but in some of the attitudes inherent in the culture of social-work and community services.

The report, prepared by Alfred J. Kahn, is available for $2 from the Committee, 112 East 19th Street, New York 3, N. Y.

Child-Welfare Legislation

Among State actions affecting children, taken in the 1957 legislative sessions, were the following:

South Dakota raised the State's maximum payments in the aid-to-dependent-children program from $65 to $75 per month for a first child but did not increase maximum payments for additional children. Under the Social Security Act the Federal Government can participate financially in ADC payments up to $64 for a caretaker and one child.

South Dakota also made an additional $8,000 per year available to the child-welfare division of the State department of public welfare for use in paying for medical and hospital care incident to the birth of a child out of wedlock when such care cannot be met throughout the department's other programs.

In an effort to "eliminate so-called black- or gray-market adoptions," *Connecticut* enacted a law requiring that, except in adoption by certain blood relatives or stepparents, no adoption application may be filed unless the child has been placed by the State welfare commissioner, an agency licensed by the commissioner, or an out-of-State agency having written consent from the commissioner to make the placement.

Montana set up a requirement for a mandatory waiting period before completion of adoption and provided for the licensing of child-placing agencies, specifying provision under which licenses may be refused or withdrawn. The Montana legislature also directed the governor to appoint a committee to study and codify the laws on the welfare of delinquent, dependent, and neglected children.

Minnesota provided for the establishment of a residential treatment center for emotionally disturbed and psychotic children and for a reception and diagnostic center for delinquent youth. Minnesota's legislature also made it possible for certain private children's agencies licensed by the State department of public welfare to charge adoptive parents up to $300 for services rendered in connection with the placement of a child for adoption.

Arizona authorized its State department of public welfare to license day-care centers for children.

Texas established a Youth Council charged with administering the State training schools for delinquents and its institutions for dependent and neglected children, and with studying the problem of juvenile delinquency and focusing public attention on possible solutions.

Delaware also set up a new State agency to provide services for juvenile delinquents, including the administration of the State's training schools.

Alaska set up a new department of institutions which is to establish a detention home for delinquent youth.

Ten States ratified the Interstate Compact on Juveniles, thus bringing to 23 the number of States, plus the Territory of Hawaii, which have joined in an agreement for the care and return of children who have run away from home.

California provided for the State department of education to make a study of problems relating to emotionally disturbed children in the public schools of the State. The legislation provides that the study shall include, but not necessarily be limited to, (1) a determination of the criteria now being used to identify emotionally disturbed children; (2) development of diagnostic standards which will most effectively identify such children; (3) an evaluation of the effectiveness of present school programs designed to help emotionally disturbed children; (4) a determination of the relationship between early identification of such children and their rehabilitation; (5) an analysis of administrative and financial problems which would be involved in the development and operation of successful programs for emotionally disturbed children. An appropriation of $68,000 has been authorized for the first year of the study.

Through the combined efforts of many groups (concentrated in an interim legislative committee), *Missouri* has overcome the failures of five previous attempts and passed a new juvenile-court law. Among other provisions, the law permits combination of rural judicial circuits to secure court personnel and detention services and requires court hearings and restrictions on the use of police and court records on juveniles. It also expresses the philosophy that children be treated in their own homes whenever possible. The new act falls short of the hopes of some of its backers in several respects, such as the type of cases coming under the jurisdiction of the court and personnel requirements, tenure, and salaries.

Adoption

Alien children whom American citizens plan to adopt may come into the United States for permanent residence on nonquota visas until June 30, 1959, under legislation enacted recently by the 85th Congress amending the Immigration and Naturalization Act. Such adoptive parents must first satisfy the Attorney General that they will adopt the child and give him good care and that they have met the preadoption requirements of their State. Children already adopted may similarly be admitted as immigrants on nonquota visas during the period. The act sets no limit on the number of children allowed entry under this provision.

A child to whom a special nonquota visa is issued must be under 14 and must have been born in a country whose immigration quota is oversubscribed. He must be an orphan, a term used in the act to apply not only to a child whose parents are dead but also to a child whose parents have disappeared or are otherwise separated from him, or whose only parent is incapable of caring for him and has released him, in writing, for emigration and adoption. Illegitimate as well as legitimate children are eligible for immigration under the act.

Another provision of the new law broadens the definition of "stepchild" as used in connection with immigration and naturalization to include a child born out of wedlock.

The act also permits permanent residence in the United States to children admitted as parolees under the provisions of the Refugee Relief Act of 1953 as amended, if they were later adopted by American citizens.

(Public Law 85-316, approved September 11, 1957.)

. . .

A kit of material on recruiting adoptive homes for Negro children has been distributed by the Maryland State Department of Public Welfare to local voluntary child-placing agencies and county welfare departments. The kit includes reports from various agencies on methods used to find homes for Ne-

gro children; digests of literature on the subject; samples of material prepared for newspapers, radio, and television; a copy of a folder answering frequently encountered questions; and suggestions for agency action. Among these suggestions are: getting in touch with couples who do not return after their first visit to the agency and following flexible policies on accepting applications.

Public Health

To help communities cope with new and changing health problems, including those of the nuclear age, the American Public Health Association is beginning a long-range technical-development program. In its early stages the program will concentrate on eight areas: radiological health, accident prevention, mental health, chronic disease and rehabilitation, child health, environmental health, and administration of medical care and of public health.

The technical-development program represents the first step in a 3-year plan of expansion and reorganization, which was recommended by a task force of public-health authorities and adopted by the association at its 1956 annual meeting. The total expansion is expected to add $250,000 to the association's annual operating budget. The Rockefeller Foundation has made a grant of $150,000 to help finance new activities during the 3-year developmental period.

UNICEF Plans

At a meeting last September the Executive Board of UNICEF approved a program allocating more than $12 million to 80 projects in 53 countries or territories, bringing the total allocation for all purposes in 1957 to over $24 million.

The United States contribution for 1958, announced at the board meeting, is for $11 million, an increase of $1 million, with the proviso that it not exceed 52½ percent of the amount contributed by all governments.

Malaria eradication will continue to receive a large share of UNICEF funds. Real progress toward this goal was reported as having been achieved in many parts of the world in cooperation with WHO and bilateral aid.

A review of maternal and child-welfare programs conducted over the past year by UNICEF and WHO provided the basis for recommendations for strengthening and improving this segment of the UNICEF program. Pediatric education, in fact training of all kinds but especially of supervisory staff, was pointed out as a great need. The board approved as sound the practice of making MCH a part of total community health programs.

The adoption of a comprehensive nutrition policy reemphasized nutrition, long a major part of the UNICEF program. The program designed in cooperation with FAO and WHO contains five parts: (a) surveys; (b) training of national public-health personnel in nutrition; (c) nutrition education for families; (d) assistance to villages in helping people put into practice what they have learned about nutrition; (e) supplementation of staple foods with vitamins. The major emphasis will be on nutrition education of mothers and children, through existing MCH personnel, who will be given refresher training in the subject.

Safety

As the result of the electrocution of a 5-year-old child while riding on an electric "kiddie ride," authorities in Westchester County, N. Y., recently sponsored a spot check in six communities of the rocket ships, planes, boats, horses, and other electrical devices for giving children rides, found in supermarkets, railroad stations, amusement parks, and other public places. Only 25 percent of the 73 devices tested were found to be safe; 26 percent were judged "dangerous"; 49 percent, "potentially hazardous." The defects included leakage of current, inadequacy of ground wires, improper insulation of live lines, and a general lack of basic safeguards. The check was carried out by a commercial testing laboratory.

Asian Flu

Before adjourning last August Congress appropriated $800,000 to be used immediately for preventive measures against Asian influenza by the Public Health Service, Department of Health, Education, and Welfare.

Among the precautionary steps already taken by the Public Health Service have been: the conducting and promotion of research into the nature of the virus and the development of the new vaccine for combating it; the dissemination of epidemiological information; a campaign of public information and health education; conferences with medical groups on the possible organization of community programs of medical care in the event of critical shortages of medical manpower; development of a voluntary allocation plan to assure each State a fair share of vaccine; recommendations on use of the vaccine while it is in short supply.

Late in August the Association of State and Territorial Health Officers met at Washington at the invitation of the Surgeon General to exchange information, plans, and views on the influenza problem with representatives of the armed services, the American Medical Association, the American Hospital Association, the American Academy of Pediatrics, and the Public Health Service. At this meeting the director of the Commission on Influenza, Armed Forces Epidemiological Board, reported that in general children under 10 have "the highest attack rate, a high rate of complications by pneumonia and a considerable death rate from pneumonia."

The conferees adopted the recommendations of the American Academy of Pediatrics approving the use of the new vaccine for children except for those allergic to egg protein. They also accepted the academy's recommended dosage: for children 13 and over, the adult dose (1 cc.) subcutaneously; for those between 5 and 12, one-half the adult dose subcutaneously to be repeated in a week or two; for children 3 months to 5 years old, one-tenth the adult dose subcutaneously or intracutaneously, also to be repeated after a 1- or 2-week interval.

Early in September the six manufacturers of the new vaccine agreed to a proposal by the Public Health Service for allocating the vaccine among the States according to population until the supplies equal the demand.

Many communities are at this writing using their first shares of the vaccine to protect people especially needed to carry on community services, such as doctors, nurses, policemen, firemen, and communication workers.

Facts and Figures

Family income in the United States averaged about 8 percent higher in 1956 than in 1955, according to the Bureau of the Census, U. S. Department of Commerce. In 1956 of the Nation's more than 43 million families, 3.5 million, or about one-twelfth, received incomes of

$10,000 or more; 17 million, or about two-fifths, had incomes ranging between $5,000 and $10,000. About 7 million, or one-sixth, had incomes under $2,000. The remaining 16 million were in the $2,000–$5,000 bracket. The median family income in 1956 was $4,783; in 1955 it was $4,421.

Prices rose only 1.5 percent in the 1955–56 period, according to the U. S. Department of Labor Consumer Price Index.

. . .

The school year 1957–58 will see a shortage of about 135,000 qualified elementary- and high-school teachers, according to the Office of Education, U. S. Department of Health, Education, and Welfare. The shortage last year was about 120,700.

Pupil enrollment in kindergarten and grades 1–8 is expected to total about 30,670,000—an increase of 959,000 over 1956–57. High-school enrollment (grades 9–12) is expected to reach 8,424,000—an increase of 604,000. For every 100 persons aged 14–17 years, 83 will be enrolled in high school as compared to 74 per 100 so enrolled ten years ago.

Readers' Exchange

HORMUTH: *Trained personnel needed*

I agree with Rudolph Hormuth that increased public interest in the problems of the mentally retarded have brought a more proper appreciation of the importance of local community programs, and that in such local programs "clinic services" are of major significance. (See "Community Clinics for the Mentally Retarded," CHILDREN, September–October 1957.) As yet, however, no one knows what type and how many "clinics" are needed. Each present-day clinic is a pioneering unit. Therefore it would have been helpful had Mr. Hormuth's article contained a generous descriptive sampling of the operating programs, especially of their work in training specialized personnel.

Theoretically the needs of the mentally retarded could best be met if all services available to the "average" would also be automatically available to the retarded. This could best be accomplished if every health, educational, social, or other community resource included services and facilities for the retarded. Unfortunately, desirable as such a plan may seem, the present shortage of qualified personnel precludes it from being a realistic possibility. The number of physicians, social workers, psychologists, and other professionals interested and qualified to deal with the specialized needs of the retarded are so few that their skills must be concentrated. Inevitably, for years to come we will have several specialized and separate clinics for the retarded.

I would therefore like to urge that any service in the field of retardation, whether a clinic, a school, or a hospital, include in its program the training of specialized personnel. Though much of the responsibility lies with schools of higher education, we will not overcome the shortage of personnel unless training becomes an integral part of every operating service.

George Tarjan, M. D.
Superintendent and Medical Director, Pacific State Hospital, Pomona, Calif.

POLLAK: *Siblings are different*

In his book, "Social Science and Psychotherapy for Children," Dr. Otto Pollak made a contribution to social casework in stressing that which social work knew but had, in too large a measure, turned away from: the importance of considering social factors as well as intrapsychic factors in diagnosis and treatment. His emphasis on a comprehensive situational approach redirected casework focus to the family as a whole and to social factors affecting the development of the child. In the sequel, "Integrating Sociological and Psychoanalytic Concepts," he supplemented his initial social-science concepts with additional ones, in relation to which he formulated family diagnosis.

In his article, "Family Situations and Child Development" (CHILDREN, September–October 1957), Dr. Pollak has moved on from dealing with *concepts* to the formulation of four *theorems* on child development, which he believes may be helpful in directing "inquiry into channels which otherwise might remain unexplored." One of these, "The common-destiny theory of sibling development," is a generalization which cannot be readily accepted.

This seems to underestimate the broad range of constitutional differences among siblings, the uniqueness of each child, and the variations in parental attitudes related to the child's age, sex, the specific meaning of a particular child to his parents, the marital relationship at a given time, and the social and economic situation of the family. Even with the safeguards and qualifications with which Dr. Pollak surrounds this theorem, I feel that it is very controversial and that it confuses rather than clarifies or adds to present knowledge.

Esther Schour
Administrative Director, Child Care Program, Institute for Psychoanalysis, Chicago

New evidence welcomed

In reply to Mrs. Schour's question regarding the usefulness of the common-destiny theorem of sibling development, I should like to say that I take this communication as a stimulus to further research rather than as an invitation to debate. I formulated this theorem on the basis of my experience in the liaison project between social science and psychoanalytically oriented child-guidance work on which I reported in my paper. In the cases which came to my attention in the course of this project, individual pathologies in the siblings of the referred child became apparent as soon as diagnostic and therapeutic concern was turned to the total family situation. I gained similar impressions in the course of case studies which I had to make for the conduct of two seminars on family diagnosis last year.

If Mrs. Schour's rich clinical experience has provided her with case material suggesting that upon diagnostic study the siblings of emotionally disturbed children show a marked degree of mental health, I shall welcome the publication of this material. I am confident that her contribution of such clinical observations will greatly strengthen the planning of research in this area.

Otto Pollak
Professor of Sociology, University of Pennsylvania

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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ANNUAL REPORT OF THE INTER DEPARTMENTAL COMMITTEE ON CHILDREN AND YOUTH; July 1, 1956, to June 30, 1957. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1957. 79 pp. Single copies available from the Bureau without charge.

This ninth annual report of a committee representing Federal agencies conducting programs that affect the well-being of children describes the agencies' cooperative exploration of a number of problems. Among them are those affecting mentally retarded children, juvenile delinquents, children of agricultural migrants, children in the Territories, American-related children abroad, and young people in transition from school to work.

PERINATAL, INFANT, AND MATERNAL MORTALITY, 1954. Eleanor P. Hunt and Ruth R. Moore. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 42. 1957. 32 pp. Single copies available from the Bureau without charge.

Presents in tabular and graphic form selected data on births and on perinatal, infant, childhood, and maternal deaths in the United States in 1954.

PUBLIC PROGRAMS FOR CRIPPLED CHILDREN, 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 40. 1957. 28 pp. Single copies available from the Bureau without charge.

This publication reports facts about the children who received service under the federally aided State programs for crippled children in 1955—their age, sex, and color; their impairments; their geographic distribution; and the kinds and volume of services provided them. Fourteen appendix tables, four giving State-by-State information, are included.

PUBLIC CHILD WELFARE IN WISCONSIN: picture of a program. Dorothea Andrews. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Child Welfare Reports No. 7. 1957. Single copies available from the Bureau without charge.

Describing the activities of the Division for Children and Youth of the Wisconsin State Board of Public Welfare, this pamphlet notes some of the division's achievements—reduction of the number of dependent children in public institutions; advances in community services; extensive use of citizen participation; youth and adult effective foster-home licensing; a low percentage of independent placements for adoption; expanded and strengthened county child welfare programs; successful use of a citizen advisory committee; and expansion and improvement of juvenile court and law enforcement reporting systems. It lists also a number of gaps and problems requiring action.

STAFF IN PUBLIC CHILD WELFARE PROGRAMS, 1956; with trend data 1946–56. Seth Low. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 41. 1957. 34 pp. Single copies available from the Bureau without charge.

Presents information concerning full-time professional child-welfare employees of State and local public welfare departments in States receiving Federal child welfare services funds under title V, part 3, of the Social Security Act. Reports the number of such workers, their education, geographic distribution, caseloads, and salaries; personnel turnover; and educational leave.

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